SERFF Tracking Number:	*FDLA-125601712*	*State:*	*Arkansas*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*38683*
Company Tracking Number:	*AH-4/9-4100108 DEAR*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al.*		

Filing at a Glance

Company: Fort Dearborn Life Insurance Company

Product Name: Group Health Insurance - Major Medical	SERFF Tr Num: FDLA-125601712	State: ArkansasLH
TOI: H16G Group Health - Major Medical	SERFF Status: Closed	State Tr Num: 38683
Sub-TOI: H16G.001C Any Size Group - Other	Co Tr Num: AH-4/9-4100108 DEAR	State Status: Approved-Closed
Filing Type: Form	Co Status: Submitted to State	Reviewer(s): Rosalind Minor
	Author: Antionette Hill	Disposition Date: 04/21/2008
	Date Submitted: 04/09/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Expat	Status of Filing in Domicile:
Project Number: 4-100-108 DE, et al.	Date Approved in Domicile:
Requested Filing Mode: Informational	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Discretionary
Filing Status Changed: 04/21/2008	
State Status Changed: 04/21/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

OUT-OF-STATE GROUP FILING: Expatriate Program - Group Health Forms/Rates

Fort Dearborn Life Insurance Company (FDL) has agreed to replace the underwriting company for the existing Expatriate Program described below. The discretionary group and group health forms and rates have been accepted as FILED in Delaware.

SERFF Tracking Number:	*FDLA-125601712*	*State:*	*Arkansas*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*38683*
Company Tracking Number:	*AH-4/9-4100108 DEAR*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al.*		

The policy is issued to the Wilmington Trust Company (Trustee) situsedin Delaware to provide health coverage under the policy for US citizens who have been assigned by their employer to a position that requires them to reside outside the United States as a condition of their employment. This health coverage will be sold only to group clients of Blue Cross and/or Blue Shield Plans that participate in the BlueWorldwide Expat Program. THERE WILL BE NO COVERAGE PROVIDED UNDER THE EXPATRIATE PROGRAM TO INDIVIDUALS RESIDING IN ARKANSAS OR ANYWHERE IN THE UNITED STATES.

Our filing in Delaware provided Actuarial Certification of compliance with Delaware Title 18 § 3509 as follows:

1. The issuance of such group policy is not contrary to the best interest of the public;
2. The issuance of the group policy would result in economies of acquisition or administration;
3. The benefits are reasonable in relation to the premiums charged; and
4. The group is not affiliated with or controlled by (as those terms are defined in Chapter 50 of this title) an insurer unless approved by the Commissioner.

The Forms, Actuarial Memorandum/Rates, a copy of the Trust Agreement and the Delaware SERFF filing are included.

Company and Contact

Filing Contact Information

Antionette Hill, Advanced Contract Specialist	Antionette_Hill@fdlic.com
1020 31st Street	(630) 824-6064 [Phone]
Downers Grove, IL 60515-5591	(630) 824-5428[FAX]

Filing Company Information

Fort Dearborn Life Insurance Company	CoCode: 71129	State of Domicile: Illinois
1020 31st Street	Group Code: 917	Company Type: Life and Health
Downers Grove, IL 60515-5591	Group Name:	State ID Number:
(800) 633-3696 ext. [Phone]	FEIN Number: 36-2598882	

Filing Fees

Fee Required? Yes

SERFF Tracking Number:	*FDLA-125601712*	*State:*	*Arkansas*
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Fee Amount:	$200.00
Retaliatory?	Yes
Fee Explanation:	Illinois fee = $50 per form $50 x 4 forms = $200
Per Company:	No

SERFF Tracking Number:	*FDLA-125601712*	*State:*	*Arkansas*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*38683*
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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Fort Dearborn Life Insurance Company	$200.00	04/09/2008	19400111

SERFF Tracking Number:	*FDLA-125601712*	*State:*	*Arkansas*
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Project Name/Number:	*Expat/4-100-108 DE, et al.*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/21/2008	04/21/2008

SERFF Tracking Number:	*FDLA-125601712*	*State:*	*Arkansas*
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Project Name/Number:	*Expat/4-100-108 DE, et al.*		

Disposition

Disposition Date: 04/21/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FDLA-125601712*	*State:*	*Arkansas*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*38683*
Company Tracking Number:	*AH-4/9-4100108 DEAR*		
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Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al.*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Group Insurance Trust Agreement	Approved-Closed	Yes
Supporting Document	Delaware - Trust Situs State Approval	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum	Approved-Closed	Yes
Form	Group Health Insurance Policy	Approved-Closed	Yes
Form	Certificate of Health Care Benefits	Approved-Closed	Yes
Form	Certificate - Schedule of Benefits	Approved-Closed	Yes
Form	Benefit Program Application	Approved-Closed	Yes

SERFF Tracking Number:	*FDLA-125601712*	*State:*	*Arkansas*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*38683*
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Project Name/Number:	*Expat/4-100-108 DE, et al.*		

Form Schedule

Lead Form Number: 4-100-108 DE

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	4-100-108 DE	Policy/Contract/Fraternal Certificate	Group Health Insurance Policy	Initial		51	POLICY 4-100-108 DE.pdf
Approved-Closed	4-200-108	Certificate	Certificate of Health Care Benefits	Initial		51	CERT 4-200-108.pdf
Approved-Closed	4-200A-108	Schedule Pages	Certificate - Schedule of Benefits	Initial		51	CERT SOB 4-200A-108.pdf
Approved-Closed	9-100-108 DE	Application/Enrollment Form	Benefit Program Application	Initial		51	BPA 9-100-108 DE.pdf

FORT DEARBORN LIFE
INSURANCE COMPANY
Chicago, Illinois

Administrative Office:

[1020 31st Street
Downers Grove IL 60515]

[BlueWorldwide Expat℠ Program]

This policy is cancelable by
Fort Dearborn Life Insurance
Company

Policy No.: [00000]

Policyholder: [Trustee Bank]

Group: [ABC Company]

Group Number: [11111]

Group Effective Date of Coverage: [01/01/08-12/31/08]

The Policyholder is the Trustee named by the Trust agreement ("Trust"). This agreement permits certain employer groups to insure certain employees and dependents for the benefits provided by this policy.

Employer groups that do so are participants in the BlueWorldwide Expat℠ Insurance Trust and are referred to herein as the "Group".

A Group must submit a Benefit Program Application in which, it agrees to participate in the Trust and applies for the insurance provided by this Policy ("Participation"). Subject to the underwriting requirements of Fort Dearborn Life Insurance Company (hereinafter referred to as "FDL"), insurance coverage will become effective as of the Effective Date of Coverage requested on the Benefit Program Application.

The Group agrees to be bound by the terms of the Trust and this Policy, including amendments thereto, as long as the Group remains a participant in the Trust.

WHEREAS, the Group has purchased health care insurance from FDL and has executed a Benefit Program Application ("Application"); and

IN WITNESS WHEREOF, FDL hereby accepts such Application, subject to the financial and administrative relationships and responsibilities of both parties for the purpose of providing health care benefits on behalf of eligible Covered Persons.

Secretary

President

The following provisions shall govern the relationship between FDL and the Group.

I. ELIGIBILITY

The Group is eligible for coverage only (a) while the BlueWorldwide Expat℠ Program remains in existence[, and (b) while the Group's basic group hospital and medical/surgical coverage for U.S. residents is underwritten by the same Plan with which such basic coverage was in effect when this expatriate coverage was first issued, and such basic coverage is written on a Blue Cross and/or Blue Shield branded basis by such Plan].

II. ENTIRE POLICY AND CHANGES TO THE POLICY

This Policy, including the addenda, if any, attached hereto; the Schedule of Benefits, the Certificate Booklet; the Application; the premium notification letter, if any; and the Individual Applications, if any, of the Covered Persons constitute the entire contract of insurance. All statements made by the Group and Covered Persons shall, in the absence of fraud, be deemed representations and not warranties, and no such statements shall be used in defense to a claim under the Policy, unless it is contained in a written application. No change in the Policy shall be valid until approved by an executive officer of FDL and unless such approval is endorsed hereon or attached hereto. No agent has authority to change the Policy or to waive any of its provisions.

The issuance of this Policy supersedes all previous contracts or policies between the Group and FDL that are in force on the Effective Date of this Policy.

III. CERTIFICATE BOOKLETS

FDL will issue to the Group, for delivery to the Insureds, individual Certificate Booklets stating the benefits, limitations, exclusions and requirements of the Policy.

IV. PREMIUM PROVISIONS

A. Premium Rates

1. On the Effective Date of Coverage, the Individual Coverage Premium (Insured only) and, when applicable, the Family Coverage Premium (Insured and one or more dependents) shall be the amounts specified in the Application and/or a premium notification letter which shall be attached hereto and made a part of the Policy. Subsequent changes to the Individual and/or Family Coverage Premiums shall be specified in the Application and/or a premium notification letter that shall be attached hereto and made a part of the Policy.

2. If Insured contributions for coverage are not required, the Group agrees that all Eligible Persons will become covered and such persons will make no contributions toward the cost of the coverage. If Insured contributions for coverage are required, the Group agrees to give all Eligible Persons an opportunity to subscribe to the coverage and further agrees to pay the required premiums to FDL and provide for the collection of any contributions from the persons to be covered through payroll withholding or otherwise.

B. Payment of Premiums

The first premium payment is due on the Effective Date of Coverage. Subsequent premium payments are payable as specified in the Application.

C. Premium Computation

1. The premium payment due on any premium due date is the aggregate amount composed of the Individual and Family Coverage premiums for all Insureds covered for the benefits provided to the Group, as specified in the Application and/or the premium notification letter. Further, if an Eligible Person becomes a Covered Person during a Benefit Period or if a Covered Person's coverage is terminated during a Benefit Period, FDL will determine the premium due for such Covered Person for such period.

2. FDL may establish a new premium for any of the individual or aggregate benefits on any of the following dates or occurrences, upon which further premium payments, including the one then due, will be computed:

    a. Any Group anniversary date provided that FDL notifies the Group of such new premium at least thirty (30) days prior to such date;

    b. Whenever the benefits under the Policy are changed;

    c. Whenever a class of persons is made eligible or is eliminated from eligibility;

    d. Whenever the enrollment fluctuates by ten percent (10%) or more;

    e. Whenever FDL is obligated to pay any new taxes, Surcharges or other fees imposed upon or resulting from the Policy including, but not limited to, premium taxes or taxes on FDL's benefits or services provided under the Policy;

    f. Whenever there is a legislative or regulatory mandate or requirement for a change in benefits that would require additional premium.

3. If the age of a Covered Person under the Policy upon which a particular premium is based has been misstated, the Group shall be responsible for paying FDL an adjusted amount that will provide FDL with the correct premium calculated from the Coverage Date of the particular Covered Person.

D. Grace Period and Termination for Non-Payment

1. A grace period of thirty-one (31) days will be allowed for payment of any premium after the first payment. During such grace period the coverage will continue in force provided that the Group has not, prior to the premium due date, given adequate timely written notice to FDL that Participation is to be terminated as of such premium due date.

    In addition, if the Group is in default of its obligation to make any premium payment as provided hereunder or if any other default hereunder has occurred and is continuing, then any indebtedness from FDL to the Group (including any and all contractual obligations of FDL to the Group) may be offset and/or recouped and applied toward the payment of the Group's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due the Group.

2. If the Group does not pay the premium during the grace period, the coverage will be terminated, at FDL's option, on the last day of the grace period and the Group will be liable to FDL for the payment of all premiums then due, including those for the grace period.

V. GENERAL PROVISIONS

A. Records of Covered Person Eligibility and Adjustments

The Group must furnish to FDL data as may be required by FDL regarding the Covered Persons who are to be covered under the Policy. Such data may include, without limitation, a list of Covered Persons who are to be covered under the Policy, completed application cards of the Insureds, and information required for Certificate(s) of Creditable Coverage that will be issued by FDL. It is the Group's obligation to notify FDL no later than thirty-one (31) days after the effective date of any change in a Covered Person's status under the Policy. All such notifications by the Group to FDL (including, but not limited to, forms and tapes) must be furnished in a format approved by FDL and must include all information reasonably required by FDL to effect such changes. Clerical errors or delays in keeping or reporting data relative to coverage under the Policy will not invalidate coverage which would otherwise be validly in force or continue coverage which would otherwise validly terminate. However, the Group is liable for any benefits paid for a terminated Covered Person if the Group had not timely notified FDL of such Covered Person's termination.

The Group hereby agrees to indemnify and hold harmless FDL and its employees and agents for any loss, damage, expense (including, but not limited to, reasonable attorneys fees and costs) or liability that may arise from or in connection with untimely and/or inaccurate data provided by the Group to FDL or data furnished by the Group to FDL in a format not approved by FDL.

B. Audits and Corrections of Errors

During the term of coverage and within one hundred eighty (180) days after Participation terminates, the Group may, upon at least thirty (30) days prior written notice to FDL, conduct reasonable audits of FDL's records in regard to Claim Payments made under the Policy. All such audits shall be subject to FDL's written guidelines, a copy of which shall be furnished to the Group upon written request to FDL.

Any errors identified in Claim Payments will be promptly corrected by FDL subject to the terms and conditions of the Policy. The Group will assist and cooperate with FDL in recovering errors in to Covered Persons but the responsibility for such errors in shall ultimately be FDL's. However, FDL shall be responsible only for the correction of errors identified in specific Claim Payments and shall not be responsible for errors calculated to exist in a population of Claim Payments on the basis of a sample drawn from that population. Further, FDL has the right to implement reasonable administrative practices in the administration of the Policy. Minor deviations in Claim Payments from the provisions of the Policy as a result of such reasonable administrative practices shall not be considered errors.

During the term of coverage and within one hundred eighty (180) days after Participation is terminated, FDL may, upon at least thirty (30) days prior written notice to the Group, conduct reasonable audits of the Group's membership records with respect to eligibility.

C. Termination of a Covered Person's Coverage

1. If an Insured, with or without cause, ceases to be an Eligible Person, such Insured's coverage (and the coverage of other Covered Persons under Family Coverage) will automatically terminate.
2. If a Covered Person ceases to meet the definition of Covered Person, such Covered Person's coverage will automatically terminate on the date that the event occurs which causes the Covered Person to no longer meet this definition.
3. A Covered Person's coverage under the Policy will automatically terminate when such Covered Person becomes eligible for Medicare.

4. Termination of Participation automatically terminates all the coverages of all Covered Persons. It is the responsibility of the Group to notify all Covered Persons of the Participation termination, but all coverages will automatically terminate as of the effective date of Participation termination regardless of whether such notice is given.

5. No benefits are available to a Covered Person for services or supplies rendered after the date of termination of such Covered Person's coverage under the Policy, except as otherwise specifically provided in Benefit Sections of the Certificate Booklet.

6. Upon the death of an Insured, coverage for other Covered Persons under Family Coverage, if any, will continue for a period of ninety (90) days subject to any other Policy provisions relating to termination of such Covered Person's coverage, provided that Premiums continue to be paid for such coverage.

D. Certificate of Creditable Coverage

1. Unless otherwise directed by the Group in writing, FDL shall issue to individuals, whose coverage terminates during the term of this Policy, a Certificate of Creditable Coverage, based upon coverage under this Policy and information provided by the Group to FDL, in a form acceptable to FDL, regarding the individual's eligibility and termination under this Policy. A Certificate of Creditable Coverage will be issued subsequent to the following events:

   a. At the time an individual's coverage under the Policy is terminated during the term of coverage;

   b. At the time an individual ceases to be covered under COBRA or other continuation privilege; and

   c. At the request of such individual within twenty-four (24) months after the date of termination of coverage under this Policy or COBRA or other continuation.

2. A Certificate of Creditable Coverage shall include, without limitation, either (a) a statement that the individual has at least 18 months of coverage, or (b) the date any waiting period began and the date Creditable Coverage began; and the date Creditable Coverage ended, unless Creditable Coverage is continuing at the time a certificate is issued.

E. Notice and Proof of Claim

1. FDL will not be liable under the Policy unless a Claim for benefits is furnished to FDL at its Authorized Administrator's office at Claim Review Section; [BlueWorldwide Expat℠ Claims Department, P.O. Box 2711, Chicago, IL 60690 USA], within ninety (90) days following the date covered services were rendered.

2. Upon written request to FDL, the Insured will be provided with the forms necessary for filing Claims under the Policy. If such forms are not furnished within fifteen (15) days of FDL's receipt of such request, the Insured shall be deemed, with respect to the particular Claim, to have complied with the requirements of the Policy pertaining to Claim forms upon submitting to FDL within the time limit specified above for filing Claims, written notice including the Covered Person's name, age, sex and identification card number, the name and address of the Provider, the diagnosis or diagnoses, a specific itemized statement of the services rendered, including all dates of service, and the Claim Charge. An expense will be considered to have been incurred on the date the service or supply for which the Claim is made was rendered or received.

3. Failure to furnish a Claim to FDL within the time limit specified above for filing Claims shall not invalidate or reduce any Claim if it were not reasonably possible to furnish the Claim within

such time limit, provided such Claim is furnished to FDL, as soon as possible and in no event, except in the absence of legal capacity, later than one (1) year from the time the Claim is otherwise required.

4. Each Covered Person agrees that it is the Covered Person's responsibility to ensure that any Provider, Plan, insurance company, insured benefit association, governmental body or program, or any other person or entity, having knowledge of or records relating to (1) any illness or injury for which a Claim or Claims for benefits are made under the Policy, (2) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (3) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to FDL, or its agent, and agrees that any such Provider, person or other entity may furnish to FDL or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, FDL may furnish similar information and records (or copies of records) to other Blue Cross or Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance type benefits requesting the same. It is also the Covered Person's responsibility to furnish FDL and/or the Group information regarding the Covered Person's becoming eligible for Medicare.

F. Payment of Claims and Assignment of Benefits

1. Under the Policy, FDL has the right to make benefit payment either to the Covered Person or directly to the Provider of Covered Services. FDL is specifically authorized by the Covered Person to determine to whom any benefit payment should be made.

2. Once Covered Services are rendered by a Provider, the Covered Person has no right to request FDL not to pay the Claim submitted by such Provider and no such request by a Covered Person or his agent will be given effect. Furthermore, FDL will have no liability to the Covered Person or any other person because of its rejection of such request.

3. A Covered Person's claim for benefits under the Policy is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a Covered Person. Coverage under the Policy is expressly non-assignable and non-transferable and will be forfeited if the Covered Person attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

G. Covered Person/Provider Relationship

1. The choice of a Provider is solely the choice of the Covered Person and FDL will not interfere with the Covered Person's relationship with any Provider.

2. It is expressly understood that FDL does not itself undertake to furnish Hospital or medical service, but solely to make payment to a Provider for the Covered Services received by Covered Persons. FDL is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Professional services are not provided by FDL and can only be legally performed by a Provider.

3. The use of an adjective such as Plan or in modifying Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Plan, Participating or any similar modifier or the use of a term such as Non-Plan or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

4. Each Provider provides Covered Services only to Covered Persons and does not deal with or provide any services to any Group or any Group's ERISA Health Benefit Program.

H. Agency Relationships

Nothing in the Policy shall be construed to constitute the Group as an agent of FDL. The Group is the agent of the Covered Persons.

I. ERISA

This Section (I.) applies to any Group Policy which implements any employee welfare benefit plan as defined by Section 3 (2) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

1. The Group or ((i) if the Group is a trust, the grantor of such trust or (ii) if the Group is an association, each member of such association who pays premiums as a participant) has established and as sponsor maintains pursuant to other written documents a health benefit program ("Group's ERISA Health Benefit Program") through the purchase of insurance for the benefit of its eligible employees or eligible members and their dependents, which Group's ERISA Health Benefit Program is an "employee welfare benefit plan" within the meaning of ERISA. Notwithstanding anything contained in the employee welfare benefit plan document of the Group (or any Group member, if the Group is an association), the Group agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Group (or any Group member, if the Group is an association) is effective with respect to or accepted by FDL except to the extent specifically provided and accepted in the Policy or as otherwise accepted in writing by FDL. The administrator under ERISA for a Group's ERISA Health Benefit Program is the Group or such other persons (other than FDL) appointed by the Group (or (i) if the Group is a trust, by the grantor of such trust or (ii) if the Group is an association, by each member of such association who pays premiums as a participant). Nothing in a Group's ERISA Health Benefit Program will affect the obligations of FDL with respect to this Group Policy. FDL will not be required to examine the provisions of a Group's ERISA Health Benefit Program or any related trust agreement, or any modification, amendment or supplement thereto.

2. The Policy is a guaranteed benefit policy (as defined in Section 401 (b) (2) of ERISA). Participation is an asset of the Group. No assets of FDL or amounts that have been paid to FDL under the Policy are assets of or under the Group's ERISA Health Benefit Program.

J. Service Mark Regulation

On behalf of the Group and its Covered Persons, the Group hereby expressly acknowledges its understanding that participation in the Trust constitutes a contract solely between the Group and FDL. FDL is an independent corporation operating under a license with the Blue Cross and Blue Shield Association (the "Association"), an association of independent Blue Cross and Blue Shield Plans. The Association permits FDL to use the Blue Cross and Blue Shield Service Mark and FDL is not contracting as the agent of the Association. The Group further acknowledges and agrees that it is not participating based upon representations by any person other than authorized persons of FDL and that no person, entity or organization other than FDL shall be held accountable or liable to the Group for any of FDL's obligations to the Group created under the Policy. This paragraph shall not create any additional obligations whatsoever on the part of FDL, other than those created under other provisions of this Policy.

K. Applicable Law

It is the intent of the parties to the Policy that it is entered into, executed in and will be subject to and interpreted by the laws of the state of Delaware, and in the event of any controversy between the Group and/or any Covered Person and FDL, this provision will apply.

L. Incontestability

After Participation for two (2) years from the Effective Date of Coverage, no statement of the Group shall be used to void Participation; and no statement by any Insured shall be used to reduce or deny a Claim after the insurance coverage, with respect to which a Claim has been made, has been in effect two (2) years or more.

M. Limitations of Actions

No civil action shall be brought to recover under the Policy or any individual Certificate pursuant to the Policy, prior to the expiration of ninety (90) days after a Claim has been furnished to FDL in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to FDL. No extension of the time granted under the "Notice and Proof of Claim" Provisions of the Policy shall in any way extend this "Limitation of Actions" Provision.

N. Physical Examinations and Autopsy

FDL at its own expense shall have the right and opportunity to examine the person of a Covered Person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

O. Conversion Privilege

An Insured (a) whose coverage under the Policy has been terminated for any reason other than discontinuance of Participation in its entirety or with respect to insured class, or failure of the Insured to pay any required contribution, and (b) whose policy is not replaced by another group policy within thirty-one (31) days, and (c) who has been continuously covered under the Policy (and under any group policy providing similar benefits which it replaced) for at least three (3) months immediately prior to termination, shall be entitled to have issued to him, a policy of health insurance (hereafter referred to as the converted policy), on a direct payment basis, of the type of policy then available to persons in such Insured's classification, subject to the following conditions:

1. Written application for the converted policy shall be made and the first premium paid not later than the latter of (i) thirty-one (31) days after such termination or (ii) fifteen (15) days after the Insured has been given written notice of the existence of the conversion privilege, but in no event later than ninety (90) days after such termination. Written notice presented to the Insured by the Group, or mailed by the Group to the last known address of the Insured, shall constitute the giving of notice for the purpose of this provision.

2. The effective date of the converted policy shall be the day following the termination of coverage under the Policy. The conversion policy will be issued by an entity designated by FDL.

3. During the first contract year, the benefits payable under the converted contract, together with benefits payable under the group contract, shall not exceed those that would have been payable had coverage under the Policy remained in force and effect.

4. FDL or its designee may refuse to renew a contract or coverage of any person who fails to provide requested information, commits fraud or material misrepresentation in applying for any benefits under the converted contract or for other reasons approved by the Director of Business

Regulation.

5. The converted policy shall cover the Insured and the Insured's dependents who were covered by the Policy on the date of termination of the Policy.

6. A conversion policy is not required for any Insured if such Insured is or could be covered by Medicare. Furthermore, a conversion policy is not required for any Insured if (i) such Insured is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance contract; or (ii) such person is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or (iii) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law, and the benefits provided under (i), or provided or available under the sources referred to in (ii), and (iii) above for such person, together with the benefits provided by the converted policy, would result in overinsurance according to FDL's standards.

P. Reimbursement Provision

If an Insured or an Insured's covered dependent incurs expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in the Certificate, the Insured shall agree:

1. FDL has the right to reimbursement for all benefits FDL provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person or the Covered Person's legal representative as a result of that sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which FDL has provided benefits to the Covered Person, reduced by any discount applicable to the Covered Person's Claim or Claims.

2. FDL is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits FDL provided for that sickness or injury.

FDL shall have the right to first reimbursement out of all funds the Covered Person or the Covered Person's legal representative is or was able to obtain for the same expenses for which FDL has provided benefits as a result of that sickness or injury.

The Covered Person is required to furnish any information or assistance or provide any documents that FDL may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

Q. Severability

In case any one or more of the provisions contained in this Policy shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Policy, but this Policy shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

R. BlueCard

This provision applies as to services that may be rendered in the U.S. All U.S. Plans participate in a program called "BlueCard." Whenever Insureds access health care services in a Plan's geographic area, the claim for those services may be processed through BlueCard and presented to FDL for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Insureds receive covered health care services within the geographic area served by a Plan, FDL will remain responsible to the Group for fulfilling FDL's contract obligations. However, the Plan will only be responsible, in accordance with applicable BlueCard Policies, if any,

for providing such services as contracting with its participating providers and handling all interaction with its participating providers. The financial terms of BlueCard are described generally below.

Liability Calculation Method Per Claim

The calculation of the Insured's liability on claims for covered health care services processed through BlueCard will be based on the lower of the provider's billed charges or the negotiated price FDL pays the Plan.

The methods employed by a Plan to determine a negotiated price will vary among Plans based on the terms of each Plan's provider contracts. The negotiated price paid to a Plan by FDL on a claim for health care services processed through BlueCard may represent:

(i) the actual price paid on the claim by the Plan to the health care provider ("Actual Price"), or

(ii) an estimated price, determined by the Plan in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Plan's health care providers or one or more particular providers ("Estimated Price"), or

(iii) an average price, determined by the Plan in accordance with BlueCard Policies, based on a billed charges discount representing the Plan's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its providers or for a specified group of providers ("Average Price"). An Average Price may result in greater variation to the Insured and the Group from the Actual Price than would an Estimated Price.

Plans using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Insured is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Plan either (1) to use a basis for calculating the Insured's liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Plan would then calculate Insured liability for any covered health care services in accordance with the applicable state statute in effect at the time the Insured received those services.

Return of Overpayments

Under BlueCard, recoveries from a Plan or from participating providers of a Plan can arise in several ways, including, but not limited to, anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Plan will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.

VI. NOTICES

Any notice given or required under the Policy or any individual certificate will be a written notice by mail or telegraph. If such notice is given to the Group, it will be addressed to it at its office address stated in the attached Application. If such notice is given to FDL, it should be addressed to FDL at its

Authorized Administrator's office at Claim Review Section; [BlueWorldwide Expat℠ Claims Department, P. O. Box 2711, Chicago, IL 60690 USA.] If such notice is given by FDL to a Covered Person, it will be addressed to the Covered Person at the address as it appears on the records of FDL or in care of the Group. The Group and FDL may, by written notice served on the other, indicate a new address for giving such notice.

VII. RENEWABILITY OF THE COVERAGES

` The Coverages shall be renewable with respect to all Covered Persons except in the following instances:

A. Non-payment of required premiums;

B. A fraudulent act or practice or intentional misrepresentation by the Group;

C. Noncompliance with FDL's minimum participation requirements;

D. Noncompliance with FDL's employer contribution requirements;

E. Termination of the benefit plan in accordance with Section VIII, below;

F. Covered Persons' who cease to be eligible under IV.C. above; or

G. Cessation of Group's membership in a bona fide association, but only if coverage is terminated uniformly without regard to the health status of any Covered Person.

VIII. TERM AND TERMINATION OF THE POLICY

Notwithstanding any provision of this Policy to the contrary:

A. The Group may terminate Participation on the first Group anniversary date or on any premium due date after the first Group anniversary date by giving written notice to FDL at least sixty (60) days in advance.

B. Participation will be terminated, at FDL's option, if the premiums have not been timely received.

C. Participation will be terminated, at FDL's option, if the Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

D. Participation will terminate if, and on the date, the Group no longer meets the eligibility requirements of Section I herein.

E. Termination of coverage. FDL may terminate coverage if:

1. FDL discontinues this type of coverage and provides 90 days notice of such discontinuation;
2. FDL offers to the Group the option to purchase any other coverage currently being offered by FDL, if any, to a group health plan in such market; and
3. FDL acts uniformly without regard to claims experience or health status of the Group or its participants.

F. In the event of cancellation, FDL will return promptly the unearned portion of any premium paid. If the Group cancels, the earned premium shall be computed by the use of the rates last filed in Delaware. If FDL terminates, the earned premium shall be computed pro-rata.

Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

IX. DEFINITIONS APPLICABLE TO THIS POLICY

Additional definitions applicable to the Policy are contained in the Certificate Booklet.

"Benefit Program Application ("Application")" means the document through which the Group has applied for health care insurance from FDL. The Application may also include a premium notification letter.

"BlueWorldwide Expat℠ Program" means the insurance program available for use by those Plans which choose to participate in order to provide expatriate insurance products to their accounts and pursuant to which this coverage is issued.

"Certificate Booklet" means the document issued to the Group and its Insureds by FDL. The Certificate Booklet describes the health care benefit program purchased by the Group.

"Certificate of Creditable Coverage" means a certificate disclosing information relating to an individual's Creditable Coverage under a health care benefit program for purposes of reducing any preexisting condition exclusion imposed by any group health plan coverage. Under this Policy, Certificate of Creditable Coverage means a certificate issued by FDL, based upon coverage under this Policy and information provided by the Group to FDL, to an individual whose coverage under this Policy has terminated, which discloses information relating to Creditable Coverage under the Policy for the purposes of reducing any preexisting condition exclusion that may be imposed by coverage under any subsequent group health plan.

"Claim" means notification in a form acceptable to FDL that service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service including, but not limited to, the Covered Person's name, age, sex and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished, the date of service, applicable diagnosis and the Claim Charge for such service.

"Claim Charge" means the amount which appears on a Claim as the Provider's charge for service rendered to a patient, without further adjustment or reduction and irrespective of any separate financial arrangement between a Plan or FDL's Authorized Administrator and the particular provider.

"Claim Payment" means the benefit payment calculated by FDL, upon submission of a Claim, in accordance with the benefits specified in the Certificate Booklet plus any related Surcharges. All Claim Payments shall be calculated on the basis of the Provider's Eligible Charge for Covered Services rendered to the Covered Person, irrespective of any separate financial arrangement between a Plan or FDL's Authorized Administrator and the particular provider.

"COBRA" means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (RL. 99-272) which regulate the conditions and manner in which an employer can offer continuation of group health insurance to Covered Persons whose coverage would otherwise terminate under the terms of the Policy.

"Coinsurance" means a percentage of an eligible expense that a Covered Person is required to pay toward a Covered Service.

"Coverage Date" means the date on which a Covered Person's coverage under the Policy commences.

"Covered Person" means the Insured, and if Family Coverage is in force, the Insured's dependents as follows:

A. The Insured's legal spouse or domestic partner.

B. The unmarried children of the Insured or the Insured's legal spouse or domestic partner, including newborn children, children who are under the Insured's legal guardianship, children who are in the custody of the Insured pursuant to an interim court order of adoption or placement of adoption, whichever occurs first, vesting temporary care of the children in the Insured, and legally adopted children, who are under the Limiting Age specified in the Application.

C. Children, as specified in (b) above, who have attained such Limiting Age but are incapable of self-sustaining employment by reason of mental retardation or physical handicap and are dependent upon the Insured or other care providers for support and maintenance, provided such children were Covered Persons prior to attaining the Limiting Age. Once FDL has been notified of a Covered Person's disability and dependence, or from the date of the first Claim filed on behalf of such disabled and dependent Covered Person, it may require proof of such Covered Person's disability and dependency at reasonable intervals. For purposes of providing benefits under the Plan, Covered Person does not mean any person who is eligible for Medicare.

"Covered Service" means a service and/or supply specified in the Certificate Booklet for which benefits will be provided.

"Creditable Coverage" means coverage under:

A. Group health plan;

B. Health insurance coverage for medical care under any hospital or medical service policy or HMO contract offered by a health insurance issuer;

C. Medicare (Part A or B of Title XVIII of the Social Security Act);

D. Medicaid (Title XIX of the Social Security Act);

E. CHAMPUS (Title 10 U. S. C. Chapter 55);

F. The Indian Health Service or a tribal organization;

G. State health benefits risk pool;

H. Federal Employees Health Benefits Program;

I. Public health plan maintained by a State, county or other political subdivision of a State;

J. Section 5(e) of the Peace Corps Act.

"Effective Date of Coverage" means the date specified by the Group in the Application.

"Eligible Person" means an employee of the Group as described in the Eligibility Section of the Certificate Booklet.

"Eligibility Date" means the date on which an Insured becomes eligible for coverage under the Policy.

"Family Coverage" means coverage for an Insured and one or more other Covered Persons under the Policy.

"Group" means the: (1) employing entity [corporation, partnership, sole proprietor or other employer], (2) association, or (3) trust, which has executed the Application for the Policy coverage. An ERISA Health Benefit Program may not be a Group hereunder, but a sponsor of or trust implementing an ERISA Health Benefit Program may be a Group hereunder.

"Individual Coverage" means coverage under the Policy for the Insured only.

"Insured" means the person employed by the Group to whom coverage under the Policy has been extended by the Group and to whom FDL has directly or indirectly issued an identification card bearing the group number of the Group. For purposes of providing benefits under the Policy, Insured does not mean any person who is eligible for Medicare and who has elected Medicare as his/her primary coverage.

"Limiting Age" means the age specified in the Application at which coverage is automatically terminated for covered unmarried children.

"Medicare" means the programs established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

"Policy" means this document including any addenda attached hereto, the Certificate Booklet, the Application, the premium notification letter, if any, and the individual applications, if any, of the Insureds.

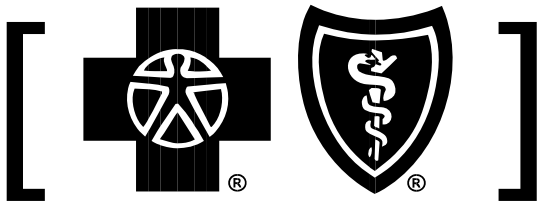
"Plan" means an entity licensed by the Blue Cross and Blue Shield Association to do business as a Blue Cross Plan, a Blue Shield Plan or a Blue Cross and Blue Shield Plan, depending upon the type of plan involved on a case-by-case basis.

"Provider" means any health care facility, person or entity duly licensed to render Covered Services to a Covered Person.

"Provider's Eligible Charge" means (a) in the case of a Provider which has a written agreement with FDL to provide care to Covered Persons at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with FDL to provide care to Covered Persons at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services, not to exceed the reasonable charge therefor as reasonably determined by the Plan.

"Service Mark" means the names BLUE CROSS and/or BLUE SHIELD and the associated logos, along with all related or derivative marks including, but not limited to, any Blue Cross or Blue Shield formulations or designs.

"Surcharges" means state or federal taxes, surcharges, or other fees paid by FDL which are imposed upon or resulting from this Policy.



[BlueWorldwide Expat℠ Program]

Underwritten by Fort Dearborn Life Insurance Company

[Comprehensive Option]

A message from,

FORT DEARBORN LIFE
INSURANCE COMPANY
Chicago, Illinois
(hereinafter referred to as "FDL")

Administrative Office: [1020 31st Street, Downers Grove IL 60515]

This booklet is your Certificate of Health Care Benefits.

Your Group has entered into an agreement with Fort Dearborn Life Insurance Company. Like most people, you probably have many questions about your coverage. This Certificate contains a great deal of information about the services and supplies for which benefits will be provided under your health benefit program. Please read your entire Certificate very carefully. We hope that most of the questions you have about your coverage will be answered.

In this Certificate we refer to Fort Dearborn Life Insurance Company as "FDL" and we refer to the company in the United States that provides you with these benefits as the "Group." The Definitions Section will explain the meaning of many of the terms used in this Certificate. All terms used in this Certificate, when defined in the Definitions Section, begin with a capital letter. Whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

The Aggregate Annual Benefit Maximum on the Schedule of Benefits is the maximum amount of benefits to which you are entitled under the program for all your Covered Services combined.

If you have any questions once you have read this Certificate, talk to your Group Administrator. It is important to all of us that you understand the protection this coverage gives you.

We are pleased to offer this program to you and your family. We believe it will help relieve you of many financial worries should you have health care expenses anywhere in the world.

Secretary

President

NOTICE

THIS COVERAGE IS ONLY AVAILABLE FOR EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS OUTSIDE OF THE UNITED STATES.

TABLE OF CONTENTS

DEFINITIONS SECTION

Throughout this Certificate, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this Certificate, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

ACUPUNCTURE means the insertion of needles into the human body by piercing the skin of the body, for the purpose of controlling and regulating the flow and balance of energy in the body.

ADVANCED PRACTICE NURSE means a duly licensed Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

AGGREGATE ANNUAL BENEFIT MAXIMUM means the maximum amount of benefits to which you are annually entitled under the program for all covered services combined.

AMBULANCE TRANSPORTATION means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

AMBULATORY SURGICAL FACILITY means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

ANESTHESIA SERVICES means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist that may be legally rendered by them respectively.

AUTHORIZED ADMINISTRATOR means a company appointed by FDL to administer or deliver benefits listed in this Certificate

BENEFIT PERIOD means the valid dates as shown in the Schedule of Benefits.

BlueWorldwide Expat℠ Program means the insurance program available for use by those Plans that choose to participate in order to provide expatriate insurance products to their accounts and pursuant to which this coverage is issued.

CERTIFICATE means this booklet, the Schedule of Benefits, including your application for coverage under the FDL benefit program described in this booklet.

CERTIFICATE OF CREDITABLE COVERAGE means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program.

CERTIFIED NURSE-MIDWIFE means a nurse-midwife who (a) practices according to the standards of the appropriate local licensing authority; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of a program of nurse-midwives accredited by the appropriate local licensing

authority.

CHEMOTHERAPY means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR means a duly licensed chiropractor.

CLAIM means notification in a form acceptable to FDL that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which FDL may request in connection with services rendered to you.

CLAIM CHARGE means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between a Plan or our Authorized Administrator and a particular Provider. (See provisions of this Certificate regarding "Separate Financial Arrangements with Providers.")

CLAIM PAYMENT means the benefit payment calculated by FDL, after submission of a Claim, in accordance with the benefits described in this Certificate. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between a Plan or our Authorized Administrator and a particular Provider. (See provisions of this Certificate regarding "Separate Financial Arrangements with Providers.")

CLINICAL LABORATORY means a clinical laboratory that complies with the licensing and certification requirements under the applicable federal, state and local laws.

COBRA means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this Certificate.

COINSURANCE means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY means all physical effects suffered as a result of pregnancy that would not be considered the effect of normal pregnancy.

COORDINATED HOME CARE means an organized skilled patient care program in which care is provided in the home. Such home care may be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of, a registered professional nurse, and the services of physical therapists, hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service.

COPAYMENT means a specified dollar amount that you are required to pay towards a Covered Service.

COUNTRY OF ASSIGNMENT means the geographic location outside the U.S. to which you have been assigned for full time employment by your employer.

COURSE OF TREATMENT means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE means the date on which your coverage under this Certificate begins.

COVERED PERSON means the Insured, and if Family Coverage is in force, the Insured's dependents as follows:

A. The Insured's legal spouse or Domestic Partner.

B. The unmarried children of the Insured or the Insured's legal spouse or domestic partner, including newborn children, children who are under the Insured's legal guardianship, children who are in the custody of the Insured pursuant to an interim court order of adoption or placement of adoption, whichever occurs first, vesting temporary care of the children in the Insured, and legally adopted children, who are under the Limiting Age specified in the Application.

C. Children, as specified in B. above, who have attained such Limiting Age but are incapable of self-sustaining employment by reason of mental retardation or physical handicap and are dependent upon the Insured or other care providers for support and maintenance, provided such children were Covered Persons prior to attaining the Limiting Age. Once FDL has been notified of a Covered Person's disability and dependence, or from the date of the first Claim filed on behalf of such disabled and dependent Covered Person, it may require proof of such Covered Person's disability and dependency at reasonable intervals. For purposes of providing benefits under the Plan, Covered Person does not mean any person who is eligible for Medicare.

COVERED SERVICE means a service and supply specified in this Certificate for which benefits will be provided.

CREDITABLE COVERAGE means coverage you had under any of the following:

(i) A group health plan;

(ii) Health insurance coverage for medical care under any hospital or medical service policy or HMO contract offered by a health insurance issuer;

(iii) Medicare (Part A or B of Title XVIII of the Social Security Act);

(iv) Medicaid (Title XIX of the Social Security Act);

(v) CHAMPUS (Title 10 U. S. C. Chapter 55);

(vi) The Indian Health Service or a tribal organization;

(vii) A State health benefits risk pool;

(viii) The Federal Employees Health Benefits Program;

(ix) A public health plan maintained by a State, county or other political subdivision of a State;

(x) Section 5(e) of the Peace Corps Act.

CUSTODIAL CARE SERVICE means those services that do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Examples of Custodial Care Service are: assistance with activities of daily living, administration of oral medications, assistance in walking, turning and positioning in bed, and acting as a companion or sitter. Custodial Care Service also means providing Inpatient service and supplies to you if you are not receiving Skilled Nursing Service on a continuous basis and/or you are not under a specific therapeutic program which has a reasonable expectancy of improving your condition within a reasonable period of time and which can only be safely and effectively administered to you as an Inpatient in the health care facility involved.

DENTAL PROSTHESIS means prosthetic services including crowns, inlays and implants services, as well as all necessary treatments including laboratory and materials.

DENTIST means a duly licensed dentist.

DOCTOR of ACUPUNCTURE means a person licensed to practice the art of healing known as acupuncture.

DIAGNOSTIC SERVICE means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

DIALYSIS FACILITY means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

EARLY INTERVENTION SERVICES means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, and assistive technology services and devices for dependents from birth to age three who are certified by the by the Department of Human Services as eligible for services under Part C of the Individuals with Disabilities Education Act.

ELIGIBLE CHARGE means (a) in the case of a Provider other than a Professional Provider which has a written agreement with a Plan and/or our Authorized Administrator to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider other than a Professional Provider which does not have a written agreement with a Plan and/or our Authorized Administrator to provide care to you at the time Covered Services are rendered, either of the following charges for Covered Services as determined at the discretion of a Plan and/or our Authorized Administrator:

(i) the charge which the particular Hospital or facility usually charges its patients for Covered Services, or

(ii) the charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by a Plan and/or our Authorized Administrator.

ELIGIBLE PERSON means an employee of the Group who meets the eligibility requirements for this health and/or dental and/or medical evacuation and repatriation coverage, as described in the ELIGIBILITY SECTION of this Certificate.

EMERGENCY ACCIDENT CARE means the initial Outpatient treatment of accidental injuries including related Diagnostic Service.

EMERGENCY MEDICAL CARE means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS ADMISSION means an admission for the treatment of Mental Illness as a result of the sudden and unexpected onset of a mental condition that the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

FAMILY COVERAGE means coverage for you and your eligible dependent(s) under this Certificate.

GROUP ADMINISTRATOR means the administrator assigned by your Group to respond to your inquiries about this coverage. The Group Administrator is not the agent of FDL.

GROUP POLICY or POLICY means the agreement between FDL and the Group, any riders, this Certificate, the Schedule of Benefits, the Benefit Program Application and any employee application form of the persons covered under the Policy.

HEARING AIDS means any non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords, and other assistive listening devices, including, but not limited to FM systems.

HOME COUNTRY means the Eligible Person's domicile or primary country of citizenship.

HOSPICE CARE PROGRAM SERVICE means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

HOSPITAL means any establishment that is licensed in the country where it operates and where the medical practitioner permanently supervises the patient. The following establishments are not considered as hospitals: rest and nursing homes, spas, cure-centers, and health resorts.

INDIVIDUAL COVERAGE means coverage under this Certificate for yourself but not your spouse and/or dependents.

INFERTILITY means the condition of an otherwise presumably healthy married individual who is unable to conceive or produce conception during a period of one year.

INPATIENT means that you are a registered bed patient and are treated as such in a health care facility.

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the appropriate government agency at the time used or administered to you.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MATERNITY SERVICE means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy that, through vaginal delivery, results in an infant, who weighs *5* pounds or more.

MAXIMUM ALLOWANCE means the amount determined by a Plan that Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers in the United States of America will be based on the Schedule of Maximum Allowances. A Plan may amend these amounts from time to time.

MEDICAL CARE means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY (SEE EXCLUSIONS SECTION OF THIS CERTIFICATE)

MENTAL ILLNESS means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered to a patient, or as approved by the Authorized Administrator.

NON-U.S. RESIDENT means a U.S. Citizen residing outside of the United States.

NURSING AT HOME means physician prescribed Skilled Nursing Service at your residence immediately after or instead of inpatient or outpatient care treatment.

NURSING AT HOME CARE PROGRAM means an organized skilled patient care program in which care is provided in the home. Such home care may be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of, a registered professional nurse, and the services of physical therapists, hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service.

OCCUPATIONAL THERAPIST means a duly licensed occupational therapist.

OCCUPATIONAL THERAPY means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST means a duly licensed optometrist.

OUTPATIENT means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM means a planned program of a Hospital or Substance Abuse Treatment Facility for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in which patients spend days or nights.

PEDIATRIC PREVENTIVE CARE means those services recommended by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics when delivered, supervised, prescribed, or recommended by a physician and rendered to a child.

PHARMACY means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPIST means a duly licensed physical therapist.

PHYSICAL THERAPY means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN or DOCTOR means a general practitioner or specialist who is licensed under the law of the country, in which treatment is given, to practice medicine and is practicing within the license limits.

PLAN means an entity licensed by the Blue Cross and Blue Shield Association to do business as a Blue Cross Plan, a Blue Shield Plan or a Blue Cross and Blue Shield Plan, depending upon the type of plan involved on a case-by-case basis.

PODIATRIST means a duly licensed podiatrist.

PREAUTHORIZATION means that you must contact our Authorized Administrator to obtain authorization to receive a covered benefit. Although you can go to the Hospital or Professional Provider of your choice, your benefits will be greater when you use the services of the Hospital or Professional Provider approved by our Authorized Administrator. If you do not obtain Preauthorization, benefits will be paid at the portion of the Eligible Charge as shown in the Schedule of Benefits under Preauthorization.

PREEXISTING CONDITION means any disease, illness, sickness, malady or condition which was diagnosed or treated by a legally qualified physician prior to the effective date of coverage with consultation, advice or treatment by a legally qualified physician occurring within 6 months prior to the Coverage Date for the insured.

PRIVATE DUTY NURSING SERVICE means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse that is not providing this service as an employee or agent of a Hospital or other health care facility. Private Duty Nursing Service does not include Custodial Care Service.

PROVIDER or PROFESSIONAL PROVIDER means any health care facility (for example, a Hospital) or person (for example, a Physician, Dentist, Podiatrist, Psychologist, or Chiropractor) or entity duly licensed to render Covered Services to you.

PSYCHOLOGIST means a Registered Clinical Psychologist.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with a department of professional regulation or, in a state or country where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state or country where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

- has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or
- is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

RENAL DIALYSIS TREATMENT means one unit of service including the equipment, supplies and administrative service that are customarily considered as necessary to perform the dialysis process.

SCHEDULE OF BENEFITS means the document attached to the Certificate showing the coverage and benefit amounts provided under your Group Policy.

SERIOUS MENTAL ILLNESS means the following biologically-based mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

1. schizophrenia;
2. bipolar disorder;
3. obsessive-compulsive disorder;
4. major depressive disorder;
5. panic disorder;
6. anorexia nervosa;
7. bulimia nervosa;
8. schizo-affective disorder; and
9. delusional disorder.

SKILLED NURSING FACILITY means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensee by the appropriate governmental authority to provide such services. It does not mean institutions that provide only minimal care, Custodial Care Services, ambulatory or part-time care services or institutions that primarily provide for the care and treatment of Mental Illness, pulmonary tuberculosis or Substance Abuse.

SKILLED NURSING SERVICE means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the technical skills and professional training of an R.N. or L.P.N. and which cannot be reasonably taught to a person who does not have specialized skill and professional training.

SPEECH THERAPIST means a duly licensed speech therapist.

SPEECH THERAPY means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, previous therapeutic processes, psychosocial speech delay, behavioral problems, attention disorder, conceptual handicap or mental retardation and which is designed and adapted to promote the restoration of a useful physical function.

SUBSTANCE ABUSE means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency that develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.

SUBSTANCE ABUSE REHABILITATION TREATMENT means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician, Psychologist, or Clinical Professional Counselor, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE ABUSE TREATMENT FACILITY means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

SURGERY means the performance of any medically recognized, non-investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by our Authorized Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOTALLY DISABLED means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

USUAL AND CUSTOMARY (or U&C) FEE means the fee as reasonably determined by a Plan and/or our Authorized Administrator, which is based on the fee which the Physician, Dentist, Podiatrist, Psychologist, Clinical Social Worker, Chiropractor, or Optometrist (“Professional Provider”) who renders the particular services usually charges his patients for the same service and the fee which is within the range of usual fees other Physicians, Dentists, Podiatrists, Psychologists, Clinical Social Workers, Chiropractors, or Optometrists (“Professional Providers”) of similar training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances.

However, if a Plan and/or our Authorized Administrator reasonably determines that the Usual and Customary Fee for a particular service is unreasonable because of extenuating or unusual circumstances, the Usual and Customary Fee for such service shall mean the reasonable fee as reasonably determined by a Plan and/or our Authorized Administrator.

ELIGIBILITY SECTION

This Certificate contains information about the health care benefit program for the persons in your Group who meet the following description of an Eligible Person: A full-time expatriate employed by the Group for whom this coverage has been requested by the Group. A full-time employee is a person who is scheduled to work a minimum of 35 hours per week and who is on the permanent payroll of the Group or who has an employment contract with the Group. If you meet this description of an Eligible Person, have applied for this coverage and have received an ID card, then you are entitled to the benefits of this program.

REPLACEMENT OF DISCONTINUED GROUP COVERAGE
When your Group initially purchases this coverage and such coverage is purchased as replacement of coverage under another carrier's group policy, those persons who are Totally Disabled on the effective date of this Policy and were covered under the prior group policy will be considered Eligible Persons under this Certificate.

Your Totally Disabled Non-U.S. Resident dependents will be considered eligible dependents under this Certificate if such Non-U.S. Resident dependents meet the description of an eligible family member as specified in the Eligibility Section of this Certificate.

Your Non-U.S. Resident dependent children who have reached the limiting age of this Certificate but were covered under the prior group policy and because of a handicapped condition are dependent upon you for support and maintenance will be considered eligible dependents under this Certificate.

If you are Totally Disabled, you will be entitled to all of the benefits described in this Certificate. The benefits of this Certificate will be coordinated with the benefits under your prior group policy. Your prior group policy will be considered the primary coverage for all services rendered in connection with your disabling condition when no coverage is available under this Certificate whether due to absence of coverage in this Certificate or lack of required Creditable Coverage for a preexisting condition.

YOUR ID CARD
You will receive an identification card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE
Only your own health care expenses are covered, not the health care expenses of other members of your family. If you want coverage for other members of your family, it must be purchased. Your Non-U.S. Resident newborn children are automatically insured from the date of birth if you submit an application and a copy of the birth certificate within 4 weeks after birth.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE
Individuals to be added under Family Coverage must be Non-U.S. Residents.

You can change from Individual to Family Coverage, either because of:

- marriage or domestic partnership
- the birth or adoption of a child
- obtaining legal guardianship of a child
- previous health insurance coverage terminating which was in effect when you were first eligible to enroll for coverage under this Certificate and which is not terminating for failure to pay premiums or fraudulent cause, and where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment.

If you make application for this change within 31 days of the marriage, birth, adoption, interim court order prior to finalization of adoption or obtaining legal guardianship, your Family Coverage will be effective

from the date of the marriage, birth, adoption, interim court order prior to finalization of adoption or legal guardianship.

If you make application for Family Coverage within 31 days of the termination of previous health coverage, your Family Coverage will be effective from the date you make application for coverage.

If you do not make application for Family Coverage within those 31 days, you can make application at any time to make those changes and your Non-U.S. Resident dependents will be subject to the 540 days Preexisting Condition waiting period as described in the Preexisting Condition Waiting Period provision of this benefit section. Such changes will be effective on a date that has been mutually agreed to by your Group and FDL.

FAMILY COVERAGE
Any individual to be covered under this Family Coverage section must be a Non-U.S. Resident.

If you have Family Coverage, your health care expenses and those of your enrolled spouse, domestic partner, and your (or your spouse's or domestic partner's) enrolled unmarried children who are not more than 18 years old will be covered. Enrolled unmarried children who are full-time students not more than 24 years old will be covered. The coverage for unmarried children will end on the last day of the month in which the limiting age is reached.

Any newborn children will be covered from the moment of birth. Please notify your Group Administrator within thirty-one (31) days of the date of birth so that your membership records can be adjusted.

Any children who are dependent upon you for support and maintenance because of a handicapped condition occurring prior to reaching the limiting age will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

Any children who are under your legal guardianship or who are in your custody under an interim court order prior to finalization of adoption will be covered.

This coverage does not include benefits for grandchildren (unless such children are under your legal guardianship).

ADDING DEPENDENTS TO FAMILY COVERAGE
A dependent must be a Non-U.S. Resident in order to be added to your Family Coverage.

You can add additional dependents to your Family Coverage, either because of:

- marriage or domestic partnership
- the birth or adoption of a child
- obtaining legal guardianship of a child
- previous health insurance coverage terminating which was in effect when you were first eligible to enroll for coverage under this Certificate and which is not terminating for failure to pay premiums or fraudulent cause, and where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment.

If you make application to add additional dependents to your Family Coverage within 31 days of the marriage, birth, adoption, interim court order prior to finalization of adoption or legal guardianship, coverage for your dependents will be effective from the date of the marriage, birth, adoption, and interim court order prior to finalization of adoption or legal guardianship.

If you make application to add dependents to your Family Coverage within 31 days of the termination of

previous health coverage, your dependents coverage will be effective from the date you make application for coverage.

If you do not make application to add additional dependents to your Family Coverage within those 31 days, you can make application at any time to make those changes and your dependents will be subject to the Preexisting Condition Waiting Period as described in the Preexisting Condition Waiting Period provision of this benefit section. Such changes will then be effective on a date that has been mutually agreed to by your Group and FDL.

DOMESTIC PARTNER COVERAGE
You may add your Domestic Partner and your Domestic Partner's children the same as any other eligible dependent under the Policy. A domestic partnership shall be established when all of the following requirements are met: both persons have a common residence; both persons agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership; neither person is married or a member of another domestic partnership; the two persons are not related by blood in a way that would prevent them from being married to each other in this state; both persons are at least the age of consent; both persons are capable of consenting to the domestic partnership; both persons have executed an affidavit or document required by the Employer Group to verify the existence of the domestic partnership; and both persons are members of the same sex.

Coverage for a domestic partner will end on the earliest of:

A. the day the Insured or Domestic Partner end the domestic partnership;

B. the day the Insured or Domestic Partner gets married to another person or becomes a Domestic Partner of another person;

C. the day the Insured and Domestic Partner stop living together.

NOTE: The Insured must notify the Employer Group within thirty (30) days if there is any change in the status between the Insured and the Domestic Partner. A signed statement of termination of domestic partnership will be required.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE
Should you wish to change from Family to Individual Coverage, you may do this at any time. Your Group Administrator will provide you with the application and tell you the date that the change will be effective.

PREEXISTING CONDITION WAITING PERIOD
Your benefits (other than for Maternity Services) are subject to a Preexisting Condition waiting period of 365 days. The Preexisting Condition waiting period will begin on the Coverage Date for you and your eligible dependents (if Family Coverage is effective) and will continue for the number of days specified. This Preexisting Condition waiting period will also apply:

- to each dependent (other than newborn child or an adopted child under age 18); or
- a child under you legal guardianship if the child is enrolled within 31 days of birth, adoption, placement of adoption or legal guardianship;

for whom coverage is applied for after your Coverage Date. The Preexisting Condition waiting period for such a dependent will begin on the dependent's Coverage Date.

However, benefits for those persons who do not apply for coverage when first eligible to do so are subject to a Preexisting Condition waiting period of 540 days.

If you had health coverage prior to getting this coverage without a break in coverage of 63 days or more, your Preexisting Condition waiting period is reduced by the length of time you had Creditable Coverage. You have the right to request a Certificate of Creditable Coverage from any previous health plan or insurer and FDL will assist you in obtaining the Certificate of Creditable Coverage, if needed.

TERMINATION OF COVERAGE
You will no longer be entitled to the following health care benefits described in this Certificate if any of the following events should occur:

1. You no longer meet the previously stated description of an Eligible Person;

2. You are a dependent of someone who no longer qualifies as an Eligible Person;

3. The entire coverage of your Group terminates; or

4. You are repatriated to the United States.

Termination of the Group Policy automatically terminates your coverage under this Certificate. It is the responsibility of your Group to notify you of the termination of the Group Policy, but your coverage will automatically terminate as of the effective date of termination of the Group Policy regardless of whether such notice is given.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under this Certificate except as otherwise specifically stated in the “Extension of Benefits in Case of Termination” provisions of this Certificate or as specified below when your entire Group’s coverage terminates. However, termination of the Group Policy and/or your coverage under this Certificate shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this Certificate, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible (for example, date of marriage, date of divorce, date the limiting age is reached, or upon repatriation to the Home Country).

Upon the death of an Eligible Person, dependents under his or her family coverage will have the option to continue coverage for a period of 90 days subject to any other Certificate provisions relating to termination of such person’s coverage, provided such person makes payment for coverage.

Other options available for Continuation of Coverage are explained in the Continuation of Coverage After Termination section of this Certificate.

Upon termination of your coverage under this Certificate, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your dependent’s coverage under this Certificate.

COVERAGE IN THE UNITED STATES
Coverage under this policy is limited to 45 days from the date of arrival while temporarily visiting the United States.

EXTENSION OF BENEFITS IN CASE OF DISCONTINUANCE
If you are Totally Disabled at the time your entire Group terminates, benefits will be provided for, and limited to, the Covered Services described in this Certificate, which are related to the disability. Benefits will be provided until the first of the following occurs:

a. The end of 12 months;

b. The end of your total disability; or,

c. Your maximum benefit is reached.

It is your responsibility to notify our Authorized Administrator, and to provide, when requested by our Authorized Administrator, written documentation of such disability. This extension of benefits will not apply to the following benefit sections: Dental Benefit Section.

CONVERSION PRIVILEGE
If your coverage under this Certificate should terminate, for any reason other than discontinuance of your Group's coverage under this policy in its entirety or with respect to an insured class, and you want coverage with no interruption here is what to do:

1. Tell our Authorized Administrator or your Group Administrator that you wish to continue your coverage and you will be provided with the necessary application; and

2. Send the application and first premium to the address provided to you by our Authorized Administrator or your Group Administrator within 31 days of the date you leave your Group.

   (You will be provided with notice of this conversion privilege at least 15 days prior to the expiration of the 31 day conversion period. If you do not receive a timely notice, you will have the earlier of 15 days after being given the notice or 90 days after termination of coverage under the group contract.)

Having done so, you will then be provided with similar insurance on an individual "direct pay" basis without evidence of insurability. These direct pay benefits (and the premium charged for them) may not be exactly the same as the benefits under this Certificate. The conversion policy will be issued by an entity designated by FDL.

This coverage will be effective the day after your Group coverage terminates so long as the premiums charged for the direct pay coverage are paid when due.

Eligibility
There is no eligibility under this section if:

1. Your discontinued Group coverage is replaced within thirty-one days; or

2. You have not been insured under this coverage, or any group contract providing similar benefits which it replaces, for at least three months immediately prior to termination; or

3. Coverage under this Certificate was terminated for your failure to pay any required contribution.

We may request information from you to determine if any of the following apply. We will not be required to issue or may refuse to renew the contract or coverage of any person if:

1. Such person could be covered by Medicare;

2. Such person is covered for similar benefits by another hospital, surgical, medical or major medical expense contract; or

3. Such person is eligible for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

4. Similar benefits are provided for or available to you, pursuant to or in accordance with the requirement of any state or federal law; and

5. The benefits provided under the sources indicated in 2. above, or provided or available under the sources described in 3., or 4., together with the benefits provided by the converted contract, would result in overinsurance according to the insurer's standards.

We may refuse to renew a contract or the coverage of any person who fails to provide information we request, commits fraud or material misrepresentation in applying for any benefits under the converted contract or for other reasons approved by the Director of Business Regulation.

During the first contract year, the benefits payable under the converted contract, together with benefits payable under the group contract, shall not exceed those that would have been payable had your insurance under the group contract remained in force and effect.

PREAUTHORIZATION OF COVERED SERVICES

Our Authorized Administrator must review certain Covered Services **prior** to such services being rendered for the purpose of preauthorizing such Covered Services**.** If you do not obtain Preauthorization prior to such service being rendered, benefits will be paid at the portion of the Eligible Charge as shown in the Schedule of Benefits under Preauthorization. The following Covered Services require Preauthorization:

- All non-emergency or non-maternity Inpatient admissions,
- MRI scans,
- Nursing at Home,
- Rehabilitation treatments,
- Outpatient medical aids,
- Major dental services,
- Orthodontic dental services,
- Medical evacuation or repatriation and repatriation of remains,
- Parental accommodation,
- Mental illness services,
- Substance abuse services,
- Inpatient Maternity stays greater than 48 hours for normal vaginal delivery or 96 hours for cesarean.

Preauthorization reviews will be undertaken primarily by registered nurses and/or other personnel with clinical backgrounds.

Our Authorized Administrator's international Helpline telephone number is on your identification card.

Please read the provisions below very carefully.

INPATIENT HOSPITAL PREADMISSION REVIEW
Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate as well as the Preexisting Condition Waiting Period, if any.

Whenever your Physician recommends a non-emergency or non-maternity Inpatient Hospital admission, you must call our Authorized Administrator. This call should be made as far in advance as possible but not less than the number of business days indicated in the Schedule of Benefits prior to the Hospital admission. Although you can go to the Hospital or Professional Provider of your choice, your benefits will be greater when you use the services of the Hospital or Professional Provider approved by our Authorized Administrator. If you do not obtain Preauthorization, benefits will be paid at the portion of the Eligible Charge as shown in the Schedule of Benefits under Preauthorization.

If the proposed Hospital admission or health care services are not Medically Necessary, it will be referred to our Authorized Administrator for review. If our Authorized Administrator concurs that the proposed admission or health care services are not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised by telephone of this determination, with follow-up notification sent to you, your Physician and the Hospital. Our Authorized Administrator will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission. This notification may be sent either by letter, facsimile or electronic mail.

EMERGENCY ADMISSION REVIEW
Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate as well as the Preexisting Condition waiting period, if any.

In the event of an emergency admission, you or someone who calls on your behalf should notify our Authorized Administrator no later than 48 hours or as soon as reasonably possible after the admission has occurred.

CASE MANAGEMENT
After your case has been evaluated, you may be assigned a case manager. In some cases, if your condition would require care in a Hospital or other health care facility, the case manager may recommend an alternative treatment plan.

Alternative benefits will be provided only so long as our Authorized Administrator determines that the alternative services are Medically Necessary and cost effective. The case manager will continue to monitor your case for the duration of your condition. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under this Certificate.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of this Certificate.

LENGTH OF STAY/SERVICE REVIEW
Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate as well as the Preexisting Condition waiting period, if any.

Upon completion of the preadmission or emergency review, our Authorized Administrator will send you a letter confirming that you or your representative called our Authorized Administrator. A letter assigning a length of service or length of stay will be sent to your Physician and/ or the Hospital.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by Our Authorized Administrator. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to our Authorized Administrator's Physician for review.

MEDICALLY NECESSARY DETERMINATION
The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by our Authorized Administrator. Should our Authorized Administrator concur that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other Provider, and will specify the dates or services that are not in benefit. For further details regarding Medically Necessary care and other exclusions from coverage under this Certificate see the section entitled, "EXCLUSIONS - WHAT IS NOT COVERED."

In the event that our Authorized Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, FDL will not be responsible for any related Hospital or other health care service charge incurred.

Remember that your FDL Certificate does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, FDL will not pay

for the hospitalization, services or supplies if our Authorized Administrator decides they were not Medically Necessary.

PREAUTHORIZATION PROCEDURE
When you contact our Authorized Administrator, you should be prepared to provide the following information:

1. the name of the attending and/or admitting Physician;

2. the name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;

3. the scheduled admission and/or service date; and

4. a preliminary diagnosis or reason for the admission and/or service.

When you contact our Authorized Administrator, our Authorized Administrator:

1. will review the medical information provided and will follow up with the Provider; and

2. may determine that the services to be rendered are not Medically Necessary.

APPEAL PROCEDURE
If you or your Physician disagrees with the determination of our Authorized Administrator prior to or while receiving services, you may appeal that decision by following the procedures outlined in the CLAIM REVIEW PROCEDURES section.

FAILURE TO NOTIFY
The final decision regarding your course of treatment is solely your responsibility and our Authorized Administrator will not interfere with your relationship with any Provider. However, FDL has established the Preauthorization procedure for the specific purpose of assisting you in determining the course of treatment that will maximize your benefits provided under this Certificate.

HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services.

This section of your Certificate tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Your benefits are also subject to the Preexisting Condition waiting period. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

Remember, whenever the term "you or your" is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital. Whenever your Physician recommends a non-emergency or non-maternity Inpatient Hospital admission, you must call our Authorized Administrator. This call should be made as far in advance as possible but not less than [5] business days prior to the Hospital admission.

Inpatient Covered Services

1. Bed, Board and General Nursing Care when you are in:
   - a semi-private room
   - a private room (at semi-private room rate)
   - an intensive care unit
2. Ancillary Services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery that you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Nursing at Home Care Program

Benefits will be provided for services under a Nursing at Home Care Program.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Benefits will be provided at the percentage of the Hospital's Eligible Charge as shown in the Schedule of Benefits when you receive Inpatient Covered Services. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

If you do not get approval for a non-emergency inpatient admission from our Authorized Administrator, benefits will be paid at the portion of the Eligible Charge as shown in the Schedule of Benefits under Preauthorization.

PARENTAL ACCOMMODATION
Hospital charges for one parent or legal guardian to stay in a hospital with a covered child under the age of 12. Benefits are limited to a maximum of days per inpatient admission as shown in the Schedule of Benefits. Our Authorized Administrator must preauthorize benefits or benefits will be paid at the portion of the Eligible Charge as shown in the Schedule of Benefits.

EXTENSION OF BENEFITS IN CASE OF TERMINATION
If you are an Inpatient at the time your coverage under this Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate that are rendered by and regularly charged for by a Hospital. Benefits will be provided until you are discharged or until the end of your Benefit Period, whichever occurs first.

OUTPATIENT HOSPITAL CARE
The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation therapy treatments
3. MRI
4. Chemotherapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to surgery or Medical Care
7. Emergency Accident Care—treatment must occur within 72 hours of the accident
8. Emergency Medical Care

OUTPATIENT HOSPITAL CARE
BENEFIT PAYMENT
After you have met your Copayment, benefits will be provided at the percentage of the Hospital's Eligible Charge as shown in the Schedule of Benefits.

BENEFIT PAYMENT FOR HOSPITAL EMERGENCY CARE
After you have met your Copayment, benefits will be provided at the percentage of the Eligible Charge as shown in the Schedule of Benefits when you receive Emergency Accident Care or Emergency Medical Care.

The Authorized Administrator must be notified within 48 hours of admission for emergency care.

PHYSICIAN BENEFIT SECTION

This section of your certificate tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available, under this Benefits Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery
Benefits are available for Surgery performed by a Physician or Dentist. However, for services performed by a Dentist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under the Certificate had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;

2. excisions of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services--if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a CRNA. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

2. Assistant Surgeon—that is, a Physician, Dentist, Podiatrist or Advanced Practice Nurse who assists the operating surgeon in performing covered Surgery but only if a Hospital intern or resident is not available for such assistance.

After your Copayment, benefits for Surgery will be provided at the percent level shown in the Schedule of Benefits.

Additional Surgical Opinion
Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at the percentage of the Claim Charge as shown in the Schedule of Benefits. Your Copayment will not apply to this benefit. If you request, benefits will be provided for an additional

consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

After your Copayment, benefits for Additional Surgical Opinion will be provided at the percent level shown in the Schedule of Benefits.

Medical Care
Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital or Substance Abuse Treatment Facility; or
2. you are a patient in a Partial Hospitalization Treatment Program; or
3. you visit your Physician's office or your Physician comes to your home.

After any Copayment, Medical Care Benefits are provided at the percent shown in the Schedule of Benefits.

OTHER PHYSICIAN SERVICES

No benefits are available under this Benefit Section for the Outpatient treatment of Mental Illness not classified as Serious Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment. In addition, the Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

Consultations
Your coverage includes benefits for consultations when you are an Inpatient in a Hospital. The consultation must be requested by your attending Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who renders Surgery or Maternity Service during the same admission.

Chemotherapy

Occupational Therapy
Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Physical Therapy
Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Radiation therapy treatments

Speech Therapy
Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association or similar body. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

Diagnostic Service
Benefits will be provided for those services related to covered Surgery or Medical Care.

Spinal Manipulation
Benefits will be provided for spinal manipulations.

BENEFIT PAYMENT FOR OTHER PHYSICIAN SERVICES

After your Copayment, benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits when you receive any of the Covered Services described in this Physician Benefit Section from a Provider or from a Dentist.

EMERGENCY ACCIDENT OR MEDICAL CARE

Treatment must occur within 72 hours of the accident.

BENEFIT PAYMENT FOR EMERGENCY ACCIDENT OR MEDICAL CARE

After your Copayment, benefits will be provided at the percentage of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits.

PREVENTIVE CARE SERVICES

Benefits will be provided for preventive care services rendered to you, even though you are not ill. Benefits will be limited to the following services:

Diabetes Self-Management Training and Education
Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this Certificate. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Coverage under this Section is provided for medically necessary visits to a qualified provider upon initial diagnosis of diabetes.

Coverage is also provided for medically necessary visits to a qualified provider upon a determination by a patient's physician that a significant change in the symptoms of the medical condition has occurred.

A "significant change" in condition means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset or progression of diabetes, or a significant change in medical condition that would require a significantly different treatment regimen.

Diabetes Treatment
Benefits are also available for diabetes equipment and supplies approved by the Food and Drug Administration, oral agents for controlling blood sugar, therapeutic/molded shoes for the prevention of amputation and regular foot care examinations by a Physician or Podiatrist.

Pap Smear Test
Benefits will be provided for an annual routine cervical smear or Pap smear test for females aged 18 and older.

Mammograms
Benefits are provided for mammographic examinations according to the following schedule:

1. a baseline mammogram for asymptomatic women at least 35 years of age;
2. a mammogram every 1 to 2 years for asymptomatic women age 40 to 50, but no sooner than 2 years after a baseline mammogram;
3. a mammogram every year for asymptomatic women age 50 and over.

Benefits will also be provided for any woman when a Physician's evaluation of a woman's physical conditions, symptoms or risk factors indicate a probability of breast cancer higher than the general population.

Prostate Test and Digital Rectal Examination
Benefits will be provided for routine prostate-specific antigen tests and digital rectal examinations in accordance with American Cancer Society guidelines.

Colorectal Cancer Screening
Benefits will be provided for colorectal cancer screening for persons 50 years of age or older. Screening includes:

1. An annual fecal occult blood tests (3 specimens).
2. A flexible sigmoidoscopy every 5 years.

3. A colonoscopy every 10 years.
4. A double contrast barium enema every 5 years.

In addition, benefits will be provided for people who are considered to be high risk for colon cancer because of:

1. Family history of familial adenomatous polyposis;
2. Family history of hereditary nonpolyposis colon cancer;
3. Chronic inflammatory bowel disease;
4. Family history of breast, ovarian, endometrial, colon cancer or polyps; or
5. A background, ethnicity or lifestyle is determined to be at elevated risk.

Pediatric Preventive Care
Benefits will be provided for Pediatric Preventive Care to a covered child from birth through the age of 19 including but not limited to the following immunizations.

1. Diptheria;
2. Hepatitis B;
3. Measles;
4. Mumps;
5. Pertussis;
6. Polio;
7. Rubella;
8. Tetanus;
9. Varicella;
10. Haemophilus influenzae B; and
11. Hepatitis A.

Lead Poisoning Screening
Benefits will be provided for lead poisoning screening for children at or around 12 months of age and for children under 6 years of age who are at high risk for lead poisoning.

Wellness Care
Benefits will be provided for Covered Services rendered to you and will be limited to the following services:

1. immunizations;
2. routine physical examination;
3. routine diagnostic tests.

When you receive Covered Services for wellness care from a Provider, benefits for wellness care will be provided at [100%] of the Eligible Charge or [100%] of the Maximum Allowance after you have met your program deductible.

Early Intervention Services
Preventive care services will be provided for a covered child from birth up to the age of three (3) including but not limited to a newborn or infant screening examination before discharge from a Hospital.

BENEFIT PAYMENT FOR PREVENTIVE CARE SERVICES
After your Copayment, benefits will be provided at the percent of the Eligible Charge or Maximum Allowance as shown in the Schedule of Benefits under Preventive Care Services.

OTHER COVERED SERVICES AND SPECIAL CONDITIONS

This section of your Certificate describes “Other Covered Services” and the benefits that will be provided for them.

- Blood and blood components
- Leg, back, arm and neck braces
- Dental accident care—Dental services rendered by a Dentist or Physician that are required as the result of an accidental injury
- Allergy shots and allergy surveys
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Durable medical equipment—Benefits will be provided for such things as blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, test strips for glucose monitors and/or visual reading, injection aids, syringes, insulin pumps and appurtenances to the pumps, insulin infusion devices, lancets and lancing devices, internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support Dental Prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by our Authorized Administrator will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose
- Prosthetic appliances—Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

  a. they are required to replace all or part of an organ or tissue of the human body, or

  b. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue

  Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient’s condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required)
- Optometric services—Benefits will be provided for services that may be legally rendered by an Optometrist, provided that benefits would have been provided had such services been rendered by a Physician
- Cranial prostheses
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you as an Inpatient in a Hospital or other health care facility only when our Authorized Administrator determines that the services provided are of such a nature or degree of complexity or quantity that they could not be or are not usually provided by the regular nursing staff of the Hospital or other health care facility. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family

- Ambulance Transportation - Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation
- Acupuncture - Benefits will be provided for the services of a Doctor of Acupuncture.
- Hearing Aids - Benefits will be provided for the examination, prescription or fitting of Hearing Aids.
- CA-125 monitoring for ovarian cancer.
- Medical formulas and foods, and low protein modified formulas and food products for the treatment of inherited metabolic diseases.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

Benefits will be provided at the percentage of the Eligible Charge or the percentage of the Maximum Allowance as shown in the Schedule of Benefits for any of the Covered Services described in this section.

SPECIAL CONDITIONS
There are some special things that you should know about your benefits should you receive any of the following types of treatments:

Human Organ Transplants
Your benefits for certain human organ transplants will be limited to the amount as shown in the Schedule of Benefits. Benefits will be provided only for kidney, heart valve, heart, lung, heart/lung, or liver transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have FDL coverage each will have their benefits paid by their own FDL program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Certificate will be provided only for you and not the donor.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this Certificate will be provided for you. However, no benefits will be provided for the recipient.

In addition to the above provisions, benefits for heart, lung, heart/lung or liver transplants will be provided as follows:

- **Whenever a heart, lung, heart/lung or liver transplant is recommended by your Physician, you must contact our Authorized Administrator before your transplant Surgery has been scheduled. Our Authorized Administrator will, where possible, furnish you with the names of Hospitals that have approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung or liver transplants performed at any Hospital that does not have an approved Human Organ Transplant Coverage Program.**
- Your benefits under this coverage will begin no earlier than the number of days as shown in the Schedule of Benefits prior to the transplant Surgery and shall continue for a period of no longer than the number of days as shown in the Schedule of Benefits after the transplant Surgery. Benefits will be provided for all Inpatient and Outpatient Covered Services related to the transplant Surgery.
- Benefits will also be provided for the transportation of the donor organ to the location of the transplant Surgery.

– In addition to the other exclusions of this Certificate, benefits will not be provided for the following:

  - Cardiac rehabilitation services when not provided to the transplant recipient within 3 days after discharge from a Hospital for transplant Surgery.
  - Transportation by air ambulance for the donor or the recipient.
  - Travel time and related expenses required by a Provider.
  - Drugs that are Investigational.
  - The cost of acquisition of the organ and any costs incurred by the donor.

Cardiac Rehabilitation Services
Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services when these services are rendered to you within a six month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery, or percutaneous transluminal coronary angioplasty. Benefits will be limited to the number of days of Outpatient treatment sessions within the six month period as shown in the Schedule of Benefits.

Skilled Nursing Facility Care
The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

Benefits for Covered Services rendered in a Skilled Nursing facility will be provided at the percent of Eligible Charge level as shown in the Schedule of Benefits, after you have met your program deductible.

Ambulatory Surgical Facility
Benefits for all of the Covered Services previously described in this Certificate are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

After your Copayment, benefits for services rendered by an Ambulatory Surgical Facility for Outpatient Surgery will be provided at the percentage of the Eligible Charge as shown in the Schedule of Benefits.

Substance Abuse Rehabilitation Treatment
Benefits for all of the Covered Services previously described in this Certificate are available for Substance Abuse Rehabilitation Treatment subject to the benefit maximums indicated below. In addition, benefits will be provided if these services are rendered by a Substance Abuse Treatment Facility and will be provided at the payment levels described later in this benefit section.

Benefit Maximum for Outpatient Treatment of Substance Abuse Rehabilitation Treatment
Your benefits for outpatient substance abuse rehabilitation treatment are limited to a maximum of the number of hours shown in the Schedule of Benefits, per calendar year.

Benefit Maximum for Detoxification
You benefits for detoxification are limited to the number of detoxification occurrences or the number of days shown in the Schedule of Benefits, in any calendar year, whichever comes first.

Mental Illness Services
Benefits for all of the Covered Services previously described in this Certificate are available for the diagnosis and/or treatment of a Mental Illness. Medical Care is eligible when rendered by (1) a

Physician; (2) a Psychologist; or (3) a Clinical Social Worker or Clinical Professional Counselor working within the scope of their license. Benefits for Mental Illness not classified as a Serious Mental Illness are subject to the benefit maximums indicated below. Covered Services must be Preauthorized by our Authorized Administrator.

Benefit Payment for Inpatient treatment of Mental Illness
Benefits payment for the Inpatient treatment of Serious Mental Illness and Mental Illness not classified as Serious Mental Illness will be provided at the same payment levels as for any other condition.

Benefit Maximum for Outpatient treatment of Mental Illness
Your benefits for Outpatient treatment of Mental Illness not classified as Serious Mental Illness are limited to a maximum of visits shown in the Schedule of Benefits, per calendar year.

Benefits for Outpatient treatment of Serious Mental Illness will be provided at the payment levels previously described in this Certificate for Hospital Covered Services.

Maternity Service
Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain Preauthorization from FDL for prescribing a length of stay less than 48 hours (or 96 hours).

Infertility
Covered services related to the diagnosis of infertility shall be same as any other condition.

Covered Services related to the treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer and low tubal ovum transfer will be provided at no less than 80% of the Eligible Charge or at no less than 80% of the Maximum Allowance.

Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures will be provided only when:

- you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments; and
- you have not undergone four (4) completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two (2) more completed oocyte retrievals shall be covered.

Special Limitations
Benefits will not be provided for the following:

- Services rendered to a surrogate mother for purposes of childbirth

- Expenses incurred for cryo-preservation and storage of sperm, eggs and embryos, except for those procedures that use a cryo-preserved substance

- Non-medical costs of an egg or sperm donor.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures must be performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in-vitro fertilization or other such body as approved by the Authorized Administrator.

Temporomandibular Joint Dysfunction and Related Disorders
Benefits for all of the Covered Services previously described in this Certificate are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

Your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to an annual maximum of the percent of the Eligible Charge shown in the Schedule of Benefits.

Mastectomy —Related Services
Benefits for Covered Services related to mastectomies, including, but not limited to, 1) reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas, are the same as for any other condition.

Clinical Trials
Benefits will be provided for routine patient care costs for Covered Persons engaging in clinical trials for treatment of life threatening diseases.

[HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of 6 months or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services - Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services.

The following services are not covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Respite care;
5. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
6. Transportation, including but not limited, to Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this Certificate.

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same level as described for Inpatient Hospital Covered Services.**]**

[MEDICAL EVACUATION AND REPATRIATION SECTION

Preauthorization from our Authorized Administrator is required for all benefits under this section.

To ensure you and your family members receive quality support and assistance in the case of an emergency, your benefit program includes coverage for medical evacuation and repatriation services and this section of your Certificate explains what services are covered and how much will be paid for them.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits. Benefits will be provided only if services are rendered on or after your Coverage Date.

Remember, whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

MEDICAL EVACUATION OR REPATRIATION

a) Our Authorized Administrator will arrange and pay for the ordinary and necessary expense of air and / or surface transportation, medical care during transportation, communications and all usual and customary ancillary charges incurred in moving and transporting you to the nearest hospital where appropriate medical care is available, which may be a location other than your Home Country or Country of Assignment.

b) Our Authorized Administrator will arrange and pay for the ordinary and necessary expenses to transport you to your Home Country or Country of Assignment following a medical evacuation for subsequent in-patient hospitalization or rehabilitative treatment.

c) FDL reserves the right, at its sole discretion, to determine whether your medical condition is sufficiently serious to warrant medical evacuation, the location to which you will be evacuated and the means or method by which such evacuation or repatriation will be carried out. In making such arrangements, our Authorized Administrator may consider all relevant circumstances including, but not limited to your medical condition, the degree of urgency, your fitness to travel, airport availability, weather conditions and travel distance in determining whether transportation will be provided by private medically equipped aircraft, helicopter, regular scheduled flight, rail or land vehicle. Transportation shall be carried out under constant medical supervision, unless otherwise approved by our Authorized Administrator.

COMPANION TICKET

Following your medical evacuation and with our Authorized Administrator’s prior written approval, our Authorized Administrator will arrange and pay for the cost of one economy class round trip airfare for a relative or friend to join you if you have or will be hospitalized outside your Home Country or Country of Assignment for more than 7 days. FDL shall not be responsible for the companion's accommodation costs.

ADDITIONAL TRAVEL EXPENSES AFTER MEDICAL EVACUATION

Following your medical evacuation and with our Authorized Administrator’s prior written approval, our Authorized Administrator will arrange and pay for the reasonable and necessary cost for airfare for you to resume your trip and / or return to your Home Country or Country of Assignment.

REPATRIATION OF MORTAL REMAINS

Our Authorized Administrator will arrange and pay for all reasonable and necessary expenses for transporting your mortal remains from the place of death to your Home Country, or, if requested by a family member or legal representative and with our Authorized Administrator’s prior written approval, our Authorized Administrator will arrange and pay for the reasonable and necessary expenses for local burial at the place of death, such expenses not to exceed the cost to repatriate your mortal remains from the place of death to your Home Country.

TRANSPORTATION OF MINOR CHILDREN

If you have minor children who are left unattended as a result of your injury, illness or medical evacuation, our Authorized Administrator will arrange and pay for the cost of economy class one-way airfares for the transportation of such minor children to your Home Country or Country of Assignment.**]**

[OUTPATIENT PRESCRIPTION DRUG PROGRAM

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and this section of your Certificate explains which drugs are covered and the benefits that are available for them. Benefits will be provided only if such drugs are Medically Necessary. The limits per Benefit Period are as shown in the Schedule of Benefits.

COVERED SERVICES

The drugs for which benefits are available under this Benefit Section are:

- drugs that require, by law, a written prescription,
- injectable insulin and insulin syringes,
- Food and Drug Administration approved contraceptive drugs and devices requiring a prescription.

Benefits for these drugs will be provided when:

- you have been given a written prescription for them by your Physician, Dentist, Optometrist or Podiatrist, and
- you purchase the drugs from a Pharmacy or from a Physician, Dentist, Optometrist or Podiatrist who regularly dispenses drugs.

Benefits will not be provided, for:

- drugs used for cosmetic purposes (including, but not limited to, Retin-A/Tretinoin and Minoxidil/Rogaine),
- any devices or appliances,
- any charges that you may incur for the drugs being administered to you.

In addition, benefits will not be provided for any refills if the prescription is more than one year old.

Benefit Payment for Prescription Drugs

You must pay a Copayment amount for each prescription as shown in the Schedule of Benefits.

Benefits will be provided for the remaining Eligible Charge. One prescription means up to a 34 consecutive day supply of a drug.]

[DENTAL BENEFIT SECTION

An important part of proper health care is maintaining good dental health. Your benefit program includes coverage for dental services and this section of your Certificate explains what dental services are covered and how much will be paid for them.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by FDL until after receipt of a Dentist's or Physician's Claim form and/or the Attending Dentist's Statement. In addition, benefits will be provided only if services are rendered on or after your Coverage Date.

The benefits of this section are only available if you have attended for dental inspection and concluded all necessary treatment in the twelve month period immediately prior to your Coverage Date, or immediately prior to claiming for covered dental services, whichever is the later.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or a Physician. When the term "Dentist" is used in this Benefit Section, it will mean Dentist or Physician.

Preventive Dental Services

Your Preventive Dental benefits are designed to help you keep dental disease from starting or to detect it in its early stages. Your Preventive Dental Services are as follows:

- Oral Examinations—The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every Benefit Period;
- Prophylaxis—The routine scaling and polishing of your teeth. However, your benefits are limited to two cleanings each Benefit Period;
- Topical Fluoride Application—Benefits for this application are only available to dependent children under age 19 and are limited to two applications each Benefit Period;
- Dental X-rays—Benefits for routine X-rays are limited to one full mouth X-ray and additional bitewing X-rays every twelve months;
- Space Maintainers—Benefits for space maintainers are only available to dependent children under age 19 and not when part of orthodontic treatment;
- Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.

Primary Dental Services
Your Primary Dental benefits cover a wide range of services that can help you maintain continued good dental health. These services are as follows:

- Fillings
- Extractions, except as specifically excluded under “Special Limitations” of this Benefit Section
- Oral Surgery, except as specifically excluded under “Special Limitations” of this Benefit Section
- Endodontics
- Pulp Vitality Tests—Benefits for these tests are limited to once every twelve months.
- Apicoectomies
- Hemisection
- Biopsies of Oral Tissue
- Periodontics/Periodontal TherapyGingivectomy and gingivoplasty; gingival curettage; periodontal scaling and root planing; osseous Surgery; and mucogingival Surgery. Your benefits are limited to one full mouth treatment per Benefit Period
- Periodontal examination — Benefits for periodontal examinations are limited to two per Benefit Period
- Periodontal maintenance procedures — Benefits for periodontal maintenance procedures are limited to four per Benefit Period, however, this maximum will be reduced by any routine prophylaxes in the same Benefit Period. In addition, you must have received periodontal therapy before benefits for these procedures will be provided
- Stainless Steel Crowns
- Repair of Removable Dentures
- Recementing of Crowns, Inlays, Onlays and Bridges
- General Anesthesia/Intravenous Sedation—If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation
- Home Visits-Visits by a Dentist to your home when medically required to render a covered dental service

Major Dental Services
You must obtain Preauthorization from our Authorized Administrator before receiving services covered under this section.

Your Major Dental Benefits are designed to help you pay for certain types of more extensive dental services. These services are as follows:

- Inlays, Onlays and Crowns (other than temporary crowns and stainless steel crowns)
- Fixed Bridgework
- Bridge Repairs
- Full and Partial Dentures
- Denture Adjustments, Rebasing and Relining—During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until *5* years have elapsed. Also, benefits are not available for the replacement of a bridge or denture that could have been made serviceable.

Orthodontic Dental Services
You must obtain Preauthorization from our Authorized Administrator before receiving services covered under this section.

Up to the age of 18, Your Dental Benefits include coverage for orthodontic appliances and treatments when they are being provided to correct problems of growth and development. Orthodontic dental services are also subject to a 365 day waiting period. The limitations are as follows:

- Diagnostic benefits, including examination, study models, X-rays and all other diagnostic aids, will be provided only once in any *5* year period, beginning with the date of the first visit to the Dentist;
- Benefits for active orthodontic treatment are limited to 36 consecutive months of treatment and benefits for retention treatment are limited to 10 visits. If you are receiving treatment when your coverage begins, these time periods will be reduced by the number of months that you have been receiving treatment prior to your coverage beginning;
- Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment;
- After your orthodontic treatment has been completed, no further orthodontic benefits will be provided until *5* years have elapsed.

BENEFIT PAYMENT FOR DENTAL COVERED SERVICES

Deductible
Each Benefit Period, you must satisfy the deductible as shown in the Schedule of Benefits. This deductible applies to all Dental Services. In other words, after you incur eligible charges of more than the amount shown in the Schedule of Benefits in a Benefit Period, your benefits will begin for those services.

Benefit Payment Level
The percentage of the Eligible Charge will be paid for the Preventive Dental Services described in this Dental Benefits Section as shown in the Schedule of Benefits.

The percentage of the Eligible Charge will be paid for the Primary Dental Services described in this Dental Benefits Section as shown in the Schedule of Benefits.

The percentage of the Eligible Charge will be paid for the Major Dental Services described in this Dental Benefits as shown in Section Schedule of Benefits.

The percentage of the Eligible Charge will be paid for the Orthodontic Dental Services described in this Dental Benefits Section as shown in the Schedule of Benefits

Benefit Maximum
The maximum amount available for you in dental benefits each Benefit Period is shown in the Schedule of Benefits. This is an individual maximum. This maximum applies to all of your Dental Covered Services, except for Orthodontic Dental Services where the maximum is the amount shown in the Schedule of Benefits.

Any expenses incurred beyond the benefit maximum are your responsibility.

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

Care by More Than One Dentist
If you should change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

Alternate Benefit Program
In all cases in which there is more than one Course of Treatment possible, the benefit payment will be based upon the Course of Treatment bearing the lesser cost.

If you and your Dentist or Physician decide on personalized restorations or to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the standard procedures for dental services, as reasonably determined by our Authorized Administrator.

Estimation of Benefits
If your Dentist recommends a Course of Treatment that will cost more than [USD 250] for Major Dental Service and/or Orthodontic Dental Services, your Dentist should prepare a Claim form describing the planned treatment, copies of necessary X-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. Our Authorized Administrator will review the report and materials, taking into consideration alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated benefits which will be provided under this Benefit Section. This is not a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered.

Special Limitations
No benefits will be provided under this Benefit Section for:

1. Dental services which are performed for cosmetic purposes.

2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.

3. Oral Surgery for the following procedures:

    - surgical services related to a congenital malformation;
    - surgical removal of complete bony impacted teeth;
    - excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    - excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.

4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.

5. Hospital and ancillary charges are not covered.

6. Any services, treatments or supplies included as an eligible benefit under any other Benefit Section of this Certificate.

7. Any services, treatments or supplies included as an eligible benefit under other group hospital, medical and/or surgical coverage.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under this Certificate should terminate, benefits will continue for any dental Covered Services, except for periodontal treatment, described in this Benefit Section as long as the Covered Service was begun prior to the date your coverage terminated and is completed within 30 days of your termination date. No benefits will be provided for periodontal treatment after the termination of your Certificate.**]**

[VISION CARE PROGRAM

Your coverage includes benefits for vision care when you receive such care from a Physician, Optometrist or Optician.

The benefits of this section are subject to all of the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For vision care benefits to be available such care must be Medically Necessary and rendered and billed for by a Physician, Optometrist or Optician, and you must receive such care on or after your Coverage Date.

In addition to the definitions of this Certificate, the following definitions are applicable to this Benefit Section:

CONTACT LENSES....means ophthalmic corrective lenses, either glass or plastic, ground or molded to be fitted directly on your eye.

FRAME....means a standard eyeglass frame adequate to hold Lenses.

LENSES....means ophthalmic corrective lenses, either glass or plastic, ground or molded to improve visual acuity and to be fitted to a Frame.

OPTICIAN...means a duly licensed optician.

Benefit Period
Your vision care benefit period begins on the first date a Covered service is received after your Coverage Date and continues for a period of 12 consecutive months thereafter. Later benefit periods will begin on the first date a Covered Service is received following the expiration of your prior benefit period.

Covered Services
Benefits may be provided under this Benefit Section for the following:

[Vision Examination

Single Vision Lenses

Bifocal Single Lenses

Bifocal Double Lenses

Trifocal Lenses

Lenticular Lenses

Contact Lenses

Frames]

Special Limitations
Benefits will not be provided for the following:

1. Recreational sunglasses.
2. Medical or surgical treatment.
3. Drugs or any medication not administered for the purpose of a vision testing examination.
4. Orthoptics, vision training, subnormal vision aids, aniseikonic Lenses and tonoraphy.
5. Replacement of Lenses or Frames, which are lost or broken.

Benefit Payment for Vision Care
Benefits for Vision Care Covered Services will be provided for the services and at the payment levels listed in the Schedule of Benefits.**]**

EXCLUSIONS—WHAT IS NOT COVERED

The following services and supplies are not covered:

1. Hospitalization, services and supplies that are not Medically Necessary.

   No benefits will be provided for services that are not, in the reasonable judgment of our Authorized Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of our Authorized Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

   Hospitalization is not Medically Necessary when, in the reasonable medical judgment of our Authorized Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

   Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

   - Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
   - Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
   - Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
   - Hospitalization or admission to a nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
   - Hospitalization or admission to a hospital or other facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
   - The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

   These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

   Our Authorized Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your Certificate. In most instances this decision is made by AUTHORIZED ADMINISTRATOR AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

   The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that FDL will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with our Authorized Administrator's decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against FDL, either at law or in equity. To initiate your appeal, you must give FDL written notice of your intention to do so within 60 days after you have been notified that your Claim has been denied by writing to:

[BlueWorldwide Expat℠ Claims Department
P. O. Box 2711
Chicago, IL 60690 USA
blueclaims@blueexpat.com
phone number]

You may furnish or submit any additional documentation that you or your Physician believe appropriate. See Claim Review Procedures section for further detail.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, FDL WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF ITS AUTHORIZED ADMINISTRATOR DECIDES THEY WERE NOT MEDICALLY NECESSARY.

2. Services or supplies that are not specifically mentioned in this Certificate

3. Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits.

~~4.~~ Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government whether or not that payment or benefits are received.

5. Services and supplies for any illness or injury occurring on or after your Coverage date as a result of participation in war, riot, civil commotion or any illegal act.

6. Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war, or an accident caused directly or indirectly by nuclear reaction, nuclear radiation, or radioactive contamination, all whether controlled or uncontrolled.

7. Services or supplies that do not meet accepted standards of medical and/or dental practice.

8. Investigational Services and Supplies and all related services and supplies.

9. Custodial Care Service.

10. Routine physical examinations, unless otherwise specified in this Certificate.

11. Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions that are not specifically the result of Mental Illness.

12. Cosmetic Surgery and related services and supplies, whether or not for psychological purposes, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases that occur after your Coverage Date.

13. Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.

14. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

15. Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

16. Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

17. Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this Certificate.

18. Blood derivatives that are not classified as drugs in the official formularies.

19. Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Certificate.

20. Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

21. Routine foot care, except for persons diagnosed with diabetes.

22. Immunizations, unless otherwise specified in this Certificate.

23. Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy.

24. Hearing aids or examinations for the prescription or fitting of hearing aids unless otherwise specified in this Certificate.

25. Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group and each is covered separately under this Certificate.

26. Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational unless otherwise specified in this Certificate.

27. Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

28. Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate.

29. Investigational or experimental organ transplantation.

30. Sex change operations.

31. Injuries or treatment resulting from engagement in professional or hazardous activities of a recreational or sporting nature other than on foot.

32. Consultations performed by you, your spouse, parents or children.

33. Treatment for overweight conditions other than for morbid obesity.

34. Treatment for hair loss.

35. Non-prescription drugs.

36. Treatment to change the refraction of one or both eyes (laser eye correction), including refractive keratectomy (RK) and photorefractive keratectomy (PRK).

37. Dental treatment, dental surgery, dental prostheses and orthodontic treatment unless otherwise specified in this Certificate.

38. Contact lenses and glasses unless otherwise specified in this Certificate.

39. Medical aids unless otherwise specified in this Certificate.

40. Services and treatment related to elective abortions.

41. Sterilization or the reversal of sterilization.

42. Prescription drugs unless elected by your Group.

43. Dental services unless elected by your Group.

44. Vision care services unless elected by your Group.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program or are covered under a country's national health program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify FDL of the existence of such other coverages. Benefits available under this contract will be reduced by the amount payable under the other contracts or programs, or by the amount that would have been payable under those other contracts had the Eligible Person claimed benefits.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.

2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.

   - However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;

   - When the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent. The benefits of a contract covering that child as a dependent of the stepparent will be determined before the benefits of a contract that covers that child as a dependent of the parent without custody.

   Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify FDL, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

FDL has the right in administering these COB provisions to:

- pay any other organization an amount that it determines to be warranted if payments that should have been made by FDL have been made by such other organization under any other group program.

- recover any overpayment that FDL may have made to you, any Provider, insurance company, person or other organization.

CONTINUATION OF COVERAGE AFTER TERMINATION; and CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA)

CONTINUATION OF COVERAGE AFTER TERMINATION

Your continued coverage under this Certificate will be provided only as specified below. Please read the provisions very carefully.

The purpose of this section is to explain the continuation of coverage after termination. The benefits under this section are available to the terminated member, the surviving spouse in case of death, and any other member of the family who was covered under the plan.

If an Eligible Person's coverage under this Certificate should terminate because of involuntary layoff, the workplace ceasing to exist, the permanent reduction in size of the workforce, or death, an Eligible Person, Spouse (in case of death), and any other member of the family who was covered under group, will be entitled to continue the Hospital, Surgical-Medical and/or Major Medical coverage provided under this Certificate for himself/herself and his/her eligible dependents (if he/she had Family Coverage on the date of termination).

However, this continuation of coverage option is subject to the following conditions:

1. Continuation of coverage will not be available to you if: (a) you are eligible for Medicare, or (b) you have coverage under any other health care program which provides group hospital, surgical or medical coverage, or (c) you decide to elect coverage on a "direct pay" basis.

2. If you decide to elect coverage on an individual, "direct pay" basis, you may not, at a later date, elect the continuation of coverage option under this Certificate. Upon termination of the continuation of coverage period as explained in paragraph 5 below, the provisions of this Certificate pertaining to "Extension of Benefits in Case of Termination" will apply and you may exercise the Conversion Privilege explained in the ELIGIBILITY section of this Certificate.

3. Upon termination of employment or membership, we will provide you with written notice of this option to continue your coverage. If you decide to continue your coverage, you must notify your Group, in writing, no later than 30 days after your coverage has terminated.

4. If you decide to continue your coverage under this Certificate, you must pay your Group on a monthly basis, in advance, the total charge required by FDL for your continued coverage, including any portion of the charge previously paid by your Group. Payment of this charge must be made to FDL (by your Group) on a monthly basis, in advance, for the entire period of your continuation of coverage under this Certificate.

   If you fail to make timely payment of required charges, coverage will end once the period for which your charges have been paid, is reached.

5. Continuation of coverage under this Certificate will end on the date you become eligible for Medicare, or become covered under another health care program (which you did not have on the date of your termination) that provides group hospital, surgical or medical coverage. Your continuation of coverage under this Certificate will also end on the first to occur of the following:

   a. The date eighteen months after the date the Eligible Person's coverage under this Certificate would have otherwise ended because of termination of employment or membership;

b. The period which represents the period of continuous employment preceding termination;

c. The date on which the Group Policy is terminated. However, if this Certificate is replaced by similar coverage under another group policy, the Eligible Person will have the right to become covered under the new coverage for the amount of time remaining in the continuation of coverage period. When your continuation of coverage period has expired, the provisions of this Certificate entitled EXTENSION OF BENEFITS IN CASE OF TERMINATION (when applicable) will apply to you.

CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA)

Note: Certain employers may not be affected by **Continuation of Coverage After Termination (COBRA)**. See your employer or Authorized Administrator should you have any questions about COBRA.

An Eligible Person whose coverage under this Certificate would otherwise terminate for any of the reasons stated herein shall be entitled to continue coverage under this Certificate, subject to the terms and conditions of this Certificate and to the following provisions:

A. Duration of Continuation of Coverage

1. Continuation of coverage under this Certificate shall be provided for a period of not more than eighteen (18) months for an Eligible Person (and spouse and any other member of the family who was covered under the Certificate) whose coverage would otherwise terminate due to (1) reduction in work hours, (2) layoff or (3) termination of employment (other than by reason of such Eligible Person's gross misconduct). If an Eligible Person or one of his eligible dependents is determined under Title II or XVI of the Social Security Act to have been disabled at the time coverage would have terminated as specified in this paragraph and the Authorized Administrator is notified of such determination within sixty (60) days, continuation of coverage shall be provided for either twenty-nine (29) months or until the first day of the month following thirty (30) days from the date the person is determined under Title II of XVI of the Social Security Act to be no longer disabled, whichever is less. If any one of the events specified in paragraph A. 2. below occurs during the eighteen (18) month period specified above, coverage may be extended for an additional eighteen (18) months.

2. Continuation of coverage under this Certificate shall be provided for a period of no more than thirty-six (36) months for (1) the surviving spouse and dependent children of a deceased Eligible Person, (2) the separated or divorced spouse of an Eligible Person, including such spouse's dependent children, (3) the spouse of an Eligible Person who elects Medicare as primary coverage or (4) a dependent child whose coverage would otherwise terminate because such child has ceased to be an Eligible Person as defined in this Certificate.

3. Continuation of coverage under this Certificate shall be provided for a retiree and his eligible dependents if the employer should file for Chapter 11 Bankruptcy and such retiree loses a substantial portion of coverage within one year before or after the bankruptcy filing. Such coverage shall be continued for the lifetime of the retiree or the surviving spouse of a retiree who was deceased at the time of the bankruptcy filing. Upon the death of a retiree who had elected continuation of coverage at the time of the bankruptcy filing, continuation of coverage shall be provided for up to thirty-six (36) months for the surviving spouse and/or dependent children of such retiree.

4. Any Group may terminate continuation of coverage prior to expiration of the aforementioned time periods if (1) the Group terminates its employee welfare health benefit plans, (2) the person covered under this coverage fails to make timely payment

of any charges or premiums required (3) Eligible Person becomes covered by another group health benefit plan with no exclusion or limitation for pre-existing conditions applicable to such person or (4) the Eligible Person becomes entitled to Medicare benefits; except that entitlement to Medicare shall not be cause for terminating continuation of coverage for persons eligible as provided in paragraph A. 3. above.

5. A person who has elected continuation of coverage under this Certificate subsequently becomes covered under another group health care policy which has an exclusion for pre-existing conditions, the coverage under this Certificate shall be secondary to coverage under such other policy; except that the coverage under this Certificate shall be primary with respect to the pre-existing conditions which are excluded under such other group policy.

B. Notice of Continuation of Coverage

1. The employer must notify the Authorized Administrator within thirty (30) days of an Insured's death, entitlement to Medicare, termination, layoff or reduction in work hours or the employers filing for Chapter 11 Bankruptcy. The Eligible Person must notify the Authorized Administrator of a divorce, legal separation, a change in a dependent's status with respect to coverage under this Certificate or determination of disability under Title II or XVI of the Social Security Act. The Authorized Administrator must notify the Eligible Person of the continuation of coverage option within fourteen (14) days of the date on which the Authorized Administrator received notice from the Group or Eligible Person of a qualifying event. Notification to the spouse of an Eligible Person shall be treated as notification to all other eligible dependents living with such spouse at the time of such notification.

2. The term "Authorized Administrator" has the meaning given the term "administrator" by section 3(16)(A) of the Employee Retirement Income Security Act of 1974

C. Election of Coverage

An Eligible Person electing to continue coverage under this Certificate must notify the Group within sixty (60) days of the date on which coverage under this Certificate would otherwise terminate or within sixty (60) days of the date on which notice of the right to continuation of coverage is received, whichever is later.

D. Payment of Charges or Premiums

1. The Group may require a charge or premium for continuation of coverage which may be paid in monthly installments. To maintain continuity of coverage, the Group may also require a charge or premium for the period of coverage preceding the election of continued coverage. This initial charge or premium must be paid within forty-five (45) days of the election of continued coverage.

2. The amount of charge or premium for continuation of coverage may not exceed 102% of the amount that would be charged to an Eligible Person if he were a member of the Group or in the case of a twenty-nine (29) month coverage period as provided above in paragraph A. 1., beginning with the nineteenth (19^{th}) month through the twenty-ninth (29^{th}) month, 150% of the amount that would be charged if the Eligible Person were a member of the Group.

E. Conversion Privilege

An Eligible Person who elects to exercise his conversion privilege under this Certificate (see "Conversion" provisions of this Certificate) and converts his group coverage to an individual direct-payment coverage may not, after expiration of the sixty (60) day election period, at a later date, elect continuation of his group coverage under this Certificate. The conversion privilege of this Certificate shall be available upon termination of the continuation of coverage period.

HOW TO FILE A CLAIM

In order to obtain your benefits under this Certificate, it is necessary for a Claim to be filed with FDL. In some instances in the U.S., all you will have to do is show your ID card to your Hospital or Physician (or other Provider). They will file your Claim for you.

In most instances, however, all eligible Claims should be filed on a BlueWorldwide Expat℠ Program Claim form with the treating Physician or Provider signing all Claims forms. Claim forms are not required for those service Preauthorized by our Authorized Administrator. All Claim forms should be submitted as soon as possible to our Authorized Administrator with the original supporting documentation, invoices and receipts but no later than 90 days following the date on which your Covered Service was rendered. FDL is not obligated to pay for Covered Services after this period.

Whenever possible, our Authorized Administrator will seek to pay inpatient expenses directly to the Hospital. Claims not settled directly with Providers will be settled directly with you. The Covered Service will be reimbursed per person, after taking into consideration required Preauthorization and Copayments in this Certificate and within the limits of the Certificate. Payments will be made either in the currency used in the Certificate or in the currency of the invoices or receipts. The exchange rate of the foreign currency will be the rate prevailing on the date of payment.

Remember however, it is your responsibility to insure that the necessary Claim information has been provided to our Authorized Administrator.

Once our Authorized Administrator receives your Claim, it will be processed and the benefit payment net of your payment to the Provider can usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid. In most cases our Authorized Administrator will send the payment directly to you.

In most situations, outside the USA, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Group Administrator. If requested, forms will be furnished to you within fifteen (15) days.

2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.

3. Mail the completed Claim Form with attachments to:

[BlueWorldwide Expat℠ Claims Department
P. O. Box 2711
Chicago, IL 60690 USA
blueclaims@blueexpat.com
phone number]

All Claim forms should be submitted as soon as possible to our Authorized Administrator with the original supporting documentation, invoices and receipts but no later than 90 days following the date on which your Covered Service was rendered.

Claims not filed within the required time period will not be eligible for payment.

Should you have any questions about filing Claims, ask your Group Administrator.

FILING DENTAL CLAIMS [IF ELECTED BY YOUR GROUP]
In order to obtain your dental benefits under this Certificate, it is necessary for a Claim to be filed with our Authorized Administrator.

To file a Claim, obtain an Attending Dentist's Statement from your Group Administrator before going to your Dentist. The Attending Dentist's Statement is also used for pre-estimation of benefits. It is your responsibility to insure that the necessary Claim information has been provided to our Authorized Administrator.

You must complete and sign an Attending Dentist's Statement. As soon as treatment has ended, ask your Dentist to complete and sign the Attending Dentist's Statement, and file it with:

[BlueWorldwide Expat℠ Claims Department
P. O. Box 2711
Chicago, IL 60690 USA
blueclaims@blueexpat.com
phone number]

All Claim forms should be submitted as soon as possible to our Authorized Administrator with the original supporting documentation, invoices and receipts but no later than 90 days following the date on which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished in the succeeding calendar year.)

Claims not filed within the required time period will not be eligible for payment.

Should you have any questions about filing Claims, ask your Group Administrator.

RELEASING NECESSARY INFORMATION
You and your dependents agree to assist us in obtaining all necessary information to process a Claim. We have the right to access all medical records and to have direct discussions with the medical provider or physician. We may at our own expense request a medical examination, by our medical representative when perceived to be necessary. We may also request an autopsy where this is not forbidden by law. All information will be treated with strict confidentiality. We reserve the right to withhold benefits if you or your dependents have not honored these obligations.

If any Claim is in any respect fraudulent, intentionally exaggerated or false or if fraudulent means or devices have been used by you or your dependents or anyone acting on your behalf or their behalf, or with your authority to obtain benefit under this insurance, we will not pay any benefits for that Claim. If we have already paid benefits for that Claim before we discovered the dishonesty we can recover those benefits from you.

CLAIM REVIEW PROCEDURES
Our Authorized Administrator will process your Claims no later than 30 days after receiving them. In some cases, additional time may be needed and you will be notified of this during the first 30 day period.

First Level Appeal
If your Claim is denied (in whole or in part), you will receive a written explanation of the denial. Should your Claim be denied, you may appeal your Claim. You may submit any additional information and comments on your Claim and you must request an appeal no later than 60 days after the denial by writing to:

[BlueWorldwide Expat℠ Claims Department
P. O. Box 2711
Chicago, IL 60690 USA
blueclaims@blueexpat.com
phone number]

Also, you may review any pertinent documents held by our Authorized Administrator if you make an appointment in writing to do so. If we require additional information, we will advise you within the first three days of your request.

Within 15 days of receiving your appeal request, our Authorized Administrator will send you its decision on the Claim.

You may have someone else represent you in this appeal procedure as long as you inform our Authorized Administrator, in writing, of the name of the person who will represent you.

Expedited Claim Appeal
When an appeal concerns (a) health care services, including, but not limited to, procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee's health, or (b) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, you may request your appeal to be expedited.

Upon submission of an expedited appeal, you will be notified as soon as possible, but no later than two business days after the appeal is filed and the review agent receives all information necessary to complete the appeal.

Second Level Appeal
If your first level appeal is unsuccessful, and you want your appeal to be reviewed, you may request a second level appeal. You must request a second level appeal no later than 60 days after the first level appeal by writing to:

[BlueWorldwide Expat℠ Claims Department
P. O. Box 2711
Chicago, IL 60690 USA
blueclaims@blueexpat.com
phone number]

Also, you may review any pertinent documents held by our Authorized Administrator if you make an appointment in writing to do so. You may add information to the file by submitting it in writing.

Within 15 days of receiving your appeal request, our Authorized Administrator will send you its decision on the Claim.

You may have someone else represent you in this appeal procedure as long as you inform our Authorized Administrator, in writing, of the name of the person who will represent you.

Expedited Claim Appeal
When an appeal concerns (a) health care services, including, but not limited to, procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee's health, or (b) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, you may request your appeal to be expedited.

Upon submission of an expedited appeal, you will be notified as soon as possible, but no later than two business days after the appeal is filed and the review agent receives all information necessary to complete the appeal.

GENERAL PROVISIONS

1. **SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS**

FDL hereby informs you that its Authorized Administrator may have contracts with certain Providers for services provided outside the United States. Under certain circumstances described in such contracts with Providers, FDL, through its Authorized Administrator, may pay Providers less than their Claim Charges for services, by discount or otherwise.

BlueCard

This provision applies as to services that may be rendered in the U.S. All U.S. Plans participate in a program called "BlueCard." Under BlueCard when you obtain health care services in the U.S in an area serviced by a Plan, the amount you pay for covered services is calculated on the **lower** of:

- The billed charges for your covered services, or
- The negotiated price that the on-site Plan passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Plan. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Plan to use a basis for calculating your liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular Claim or to add a surcharge. Should any state statutes mandate calculation methods for your liability that differ from the usual BlueCard method noted above or require a surcharge, FDL would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

2. **PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS**

A. Under this Certificate, FDL has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, FDL may pay benefits to you if you receive Covered Services from a Non-Plan Provider. FDL is specifically authorized by you to determine to whom any benefit payment should be made.

B. Once Covered Services are rendered by a Provider, you have no right to request FDL not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, FDL will have no liability to you or any other person because of its rejection of such request.

C. A Covered Person's Claim for benefits under this Certificate is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Certificate is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a Claim for benefits or coverage shall be null and void.

3. **YOUR PROVIDER RELATIONSHIPS**

A. The choice of a Provider is solely your choice and FDL will not interfere with your relationship with any Provider.

B. FDL does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. FDL is not in any event liable for any act or

omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services that can only be legally performed by a Provider are not provided by FDL . Any contractual relationship between a Physician and a Plan Hospital or other Plan Provider shall not be construed to mean that FDL is providing professional service.

4. **AGENCY RELATIONSHIPS**
The Group is your agent under this Certificate. The Group is not the agent of FDL.

5. **NOTICES**
Any information or notice which you furnish to FDL under this Certificate must be in writing and sent to FDL at:

[BlueWorldwide Expat℠ Claims Department
P. O. Box 2711
Chicago, IL 60690 USA
blueclaims@blueexpat.com
phone number]

(unless another address has been stated in this Certificate for a specific situation). Any information or notice which FDL furnishes to you must be in writing and sent to you at your address as it appears on FDL records or in care of your Group and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on FDL's records.

6. **LIMITATIONS OF ACTIONS**
No legal action may be brought to recover under this Certificate, prior to the expiration of sixty (60) days after a Claim has been furnished to FDL in accordance with the requirements of this Certificate. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to FDL in accordance with the requirements of this Certificate.

7. **INFORMATION AND RECORDS**
You agree that it is your responsibility to ensure that any Provider, Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under this Certificate, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to FDL or its Authorized Administrator, and agree that any such Provider, person or other entity may furnish to its Authorized Administrator, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, FDL or its Authorized Administrator may furnish similar information and records (or copies of records) to Providers, Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish our Authorized Administrator and/or your employer or group administrator information regarding you or your dependents becoming eligible for Medicare.

REIMBURSEMENT PROVISION

If you or one of your covered dependents are injured by the act or omission of another person and benefits are provided for Covered Services described in this Certificate, you agree:

A. To immediately reimburse FDL for all Eligible Charges from any and all damages collected from the third party for those same expenses, whether by action at law, settlement or otherwise, as a result of that sickness or injury, in the amount of the total Eligible Charge for Covered Services for which FDL has provided benefits to you; and

B. That FDL will have a lien to the extent of the total Eligible Charge for Covered Services provided. Such lien may be filed with the person whose act caused the injury, the person's agent or a court having jurisdiction in the matter.

It is your responsibility to furnish any information, assistance or provide any documents that FDL or its Authorized Administrator may request in order to obtain its rights under this provision.

Fort Dearborn Life
Insurance Company
Chicago, Illinois

[Administrative Office:

1020 31st Street
Downers Grove IL 60515]

BlueWorldwide Expat℠ [Program] [Comprehensive Option] Schedule of Benefits

We will provide the insurance described below in return for the premium, subject to all the terms, conditions and limitations contained in the Certificate and the Group Policy.

Group Name:	Group Number:
Name:	[Sex:] [Status:]
Date of Birth:	[Cover Code:]
Certificate Number:	[Agency Code:]
[Home Country:]	[Country of Assignment:]
Coverage Date:	[Issue Date:]

Benefit Period: Begins on each [January 1st] and continues for the next twelve (12) consecutive months. Later benefit periods will begin on the day following the expiration of your prior benefit period and will continue for twelve (12) consecutive months thereafter.

The following benefits are covered up to an [Aggregate Annual Maximum] [Lifetime] Benefit, subject to the limits as indicated below.

[AGGREGATE ANNUAL MAXIMUM] [LIFETIME] BENEFIT	[USD 1,500,000]
[INDIVIDUAL DEDUCTIBLE]	[USD 100] per benefit period
[INDIVIDUAL OUT-OF-POCKET EXPENSE LIMIT **(does not apply to all services)**]	[USD 500] per benefit period
HUMAN ORGAN TRANSPLANT LIMIT	[USD 150,000] per transplant
SUBSTANCE ABUSE REHABILITATION TREATMENT	
--Inpatient Substance Abuse Rehabilitation Treatment – calendar year maximum	[30] days
--Outpatient Substance Abuse Rehabilitation Treatment— calendar year maximum	[30] hours
MENTAL ILLNESS NOT CLASSIFIED AS SERIOUS MENTAL ILLNESS--OUTPATIENT TREATMENT LIMIT	[30] visits per calendar year
TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS	[USD 2,500] annual maximum
PREAUTHORIZATION	
The following Covered Services require preauthorization: all non-emergency or non-maternity Inpatient admissions, parental accommodation, MRI scans, nursing at home, rehabilitation treatments, outpatient medical aids, community residential care services for substance abuse, mental illness services, Inpatient maternity stays greater than 48 hours for normal vaginal delivery or 96 hours for cesarean delivery, medical evacuation or repatriation and repatriation of remains, major dental services, and orthodontic dental services].	If Preauthorization is not obtained, our portion of Eligible Charges is paid at [50%]. [A {$300} penalty will be applied to hospital in-patient charges for failure to pre-certify admission.]

HOSPITAL BENEFITS	
Inpatient Care	[100%] of the Eligible Charge [[USD 100] deductible]
Parental Accommodation—hospital charges for one parent or legal guardian accompanying child under the age of 12	[100%] of the Eligible Charge [USD 500] maximum per inpatient admission
Outpatient Care	[100%] of the Eligible Charge [USD 50] Copayment
Emergency Care	[100%] of the Eligible Charge [No] Copayment
PHYSICIAN BENEFITS	
Surgical Care	[100%] of the Eligible Charge or Maximum Allowance [No] Copayment
Additional Surgical Opinion	[100%] of the Claim Charge [No] Copayment
Medical Care	[100%] of the Eligible Charge or Maximum Allowance [USD 50] Copayment
Emergency Accident or Emergency Medical Care	[100%] of the Eligible Charge or Maximum Allowance [No] Copayment
Other Physician Services—consultations, chemotherapy, therapy treatments, diagnostic service, and spinal manipulation.	[100%] of the Eligible Charge or Maximum Allowance [USD 50] Copayment
PREVENTIVE CARE SERVICES	
Early Intervention Services	100% of Eligible Charge No Copayment Up to 5,000 USD per dependent per benefit period Any amount paid under this benefit will not be applied to the [Aggregate Annual Maximum] [Lifetime Benefit]
Diabetes self–management training and education, pap smear test, mammograms, prostate test and digital rectal exam, colorectal cancer screening, wellness care and pediatric preventive care.	[100%] of the Eligible Charge or Maximum Allowance [USD 50] Copayment
OTHER COVERED SERVICES	
Blood, braces, dental accident care, allergy shots, oxygen, medical and surgical dressings, durable medical equipment, prosthetic appliances, optometric services, private duty nursing services, ambulance transportation, acupuncture and hearing aids	[100%] of the Eligible Charge or Maximum Allowance
SPECIAL CONDITIONS	
Human Organ Transplant Limit	[100%] of the Eligible Charge
Cardiac Rehabilitation Services	[100%] of the Eligible Charge
Ambulatory Surgical Facility	[100%] of the Eligible Charge
Skilled Nursing Facility	[100%] of the Eligible Charge
Substance Abuse Rehabilitation Treatment	
--Inpatient Substance Abuse Rehabilitation Treatment	[100%] of the Eligible Charge
--Outpatient Substance Abuse Rehabilitation Treatment	[100%] of the Eligible Charge

SPECIAL CONDITIONS (continued)	
Mental Illness	
--Inpatient treatment	[100%] of the Eligible Charge
--Outpatient treatment	[100%] of the Eligible Charge
Maternity Service	[100%] of the Eligible Charge
Infertility	[not less than 80%] of the Eligible Charge
Temporomandibular Joint Dysfunction and Related Disorders	[100%] of the Eligible Charge
Mastectomy Related Services	[100%] of the Eligible Charge
[HOSPICE CARE PROGRAM]	[100%] of the Eligible Charge [[USD 100] deductible]
[MEDICAL EVACUATION AND REPATRIATION]	
Medical Evacuation or Repatriation	[100%] of the Eligible Charge
Companion Ticket	One economy class round trip airfare
Additional Travel Expenses after Medical Evacuation	[100%] of the reasonable and necessary airfare
Repatriation of Mortal Remains	[100%] of the reasonable and necessary expenses
Transportation of Minor Children	Cost of economy class one way fare
[OUTPATIENT PRESCRIPTION DRUG PROGRAM]	
[Annual limit]	[USD 500]
Copayment	{[USD 25.00] per prescription} [100% of Eligible Charge]
[DENTAL BENEFITS]	
Benefit Period Maximum	[USD 1,500]
Deductible	[USD 100] per Benefit Period
Preventive Services Benefit Payment Level	[100%] of the Eligible Charge
Primary Services Benefit Payment Level	[100%] of the Eligible Charge
Major Services Benefit Payment Level	[100%] of the Eligible Charge
Orthodontic Services Period Maximum	[USD 3,000]
Orthodontic Services Benefit Payment Level	[100%] of the Eligible Charge
A dental inspection with all necessary dental treatment must have taken place in the 12-month period immediately prior to your Coverage Date or immediately prior to claiming dental benefits.	
[VISION CARE BENEFITS]	
Vision Examination	[$55 per exam], limited to one exam every [24] months
[Single vision lenses]	[$75 per pair]
[Bifocal single lenses]	[$80 per pair]
[Bifocal double lenses]	[$85 per pair]
[Trifocal lenses]	[$90 per pair]
[Lenticular lenses]	[$115 per pair]
[Contact lenses]	[$150 per pair]
[Frames]	[[$100] per Frame, limited to one Frame every {24} months]

For further details of coverage, including exclusions, any reductions or limitations please see your Certificate booklet. In the event of any difference in this Schedule of Benefits and the Schedule of Benefits in your Group's Benefit Program Application, the latter shall govern.

This Schedule of Benefits has been issued by the Authorized Administrator on behalf of Fort Dearborn Life Insurance Company.

Issued by
[Authorized Administrator

BlueWorldwide Expat℠ Program
P. O. Box 2711
Chicago, IL 60690 USA
Phone number]

Signed_____ [Title]

[EXCLUSIONS]

[ ]

Fort Dearborn Life
Insurance Company
Chicago, Illinois

[Administrative Office:

1020 31st Street
Downers Grove IL 60515]

[COMPREHENSIVE OPTION BENEFIT PROGRAM APPLICATION BlueWorldwide Expat℠ Program]

Application is hereby made by the undersigned Employer Group ("Group") for insurance based on the following statements and representations.

1. Name of Group: [XYZ COMPANY]

   Address: [123 MAIN STREET]

   [ANYTOWN, USA 00000]

   Quote Number: [0000000]

   Administrative Contact: [DONNA ELLIOT]

   Agent or Broker: [TONY RATLIFF]

   Effective Date of Coverage: [01/01/08]

   Group anniversary date: [01/01]

2. Group wishes the eligible persons described on the Schedule of Benefits to be eligible for coverage under the BlueWorldwide Expat℠ Program Policy, and any policies issued in replacement or substitution thereof, by Fort Dearborn Life Insurance Company ("FDL").

3. The insurance to be provided under the Policy applies only to the groups or classes of Insureds described under the Schedule of Benefits, attached, and only with respect to those coverages specified. The amount specified shall apply to each Insured as specified in the Certificate Booklet and Schedule of Benefits, subject to all the terms of the Policy relating thereto.

4. The effective date of coverage will be [01/01/08]. Premiums will be due as shown herein. The Group understands that coverage will not be effective until this application is fully executed.

5. The Group agrees to promptly furnish FDL or its Authorized Administrator with any information required by them as needed to ensure proper administration of the insurance plans. The Group further agrees to allow FDL or its Authorized Administrator to inspect all records that pertain to the insurance plans.

6. The Group agrees to pay to FDL or its Authorized Administrator all premiums, which become due and payable, and understands that any payment more than 31 days in default may cause termination of coverage and suspension of benefits as of the due date.

7. Group agrees to inform members and their dependent(s) of benefit restrictions as set out in the Certificate as well as any amendments and variations thereto.

When a copy of this Benefit Program Application is attached to and made a part of the Policy, the following shall constitute the Group's Schedule of Benefits.

SCHEDULE OF BENEFITS

1. **ELIGIBILITY:** [A Non-U.S. Resident full-time employee of the Group for whom this coverage has been requested by the Group. A full-time employee is a person who is scheduled to work a minimum of 35 hours per week and who is on the permanent payroll of the Group.]

   Family Coverage: __ Yes [X] No

   [Any individual to be covered under Family Coverage must be a Non-U.S. Resident.]

   [Unmarried dependent children must be under the Limiting Age of 18 or under age 24 if an unmarried full-time student.]

2. **BENEFIT PERIOD:** Begins on each [JANUARY 1st] and continues for the next 12 consecutive months. Later benefit periods will begin on the day following the expiration of your prior period and will continue to twelve (12) consecutive months thereafter.

3. **COVERAGE AND BENEFIT AMOUNTS**

   Eligible Persons are covered only for the BENEFITS which have BENEFIT AMOUNTS completed.

BENEFITS	BENEFIT AMOUNT
[AGGREGATE ANNUAL MAXIMUM] [LIFETIME] BENEFIT	[USD 1,500,000]
[INDIVIDUAL DEDUCTIBLE]	[USD 100] per benefit period
[INDIVIDUAL OUT-OF-POCKET EXPENSE LIMIT **(does not apply to all services)**]	[USD 500] per benefit period
HUMAN ORGAN TRANSPLANT LIMIT	[USD 150,000] per transplant
SUBSTANCE ABUSE REHABILITATION TREATMENT	
--Inpatient Substance Abuse Rehabilitation Treatment – calendar year maximum	[30] days
--Outpatient Substance Abuse Rehabilitation Treatment— calendar year maximum	[30] hours
MENTAL ILLNESS NOT CLASSIFIED AS SERIOUS MENTAL ILLNESS--OUTPATIENT TREATMENT LIMIT	[30] visits per calendar year
TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS	[USD 2,500] annual maximum
PREAUTHORIZATION	
The following Covered Services require preauthorization: all non-emergency or non-maternity Inpatient admissions, parental accommodation, MRI scans, nursing at home, rehabilitation treatments, outpatient medical aids, community residential care services for substance abuse, mental illness services, Inpatient maternity stays greater than 48 hours for normal vaginal delivery or 96 hours for cesarean delivery[, medical evacuation or repatriation and repatriation of remains, major dental services, and orthodontic dental services].	If Preauthorization is not obtained, our portion of Eligible Charges is paid at [50%]. [A {$300} penalty will be applied to hospital in-patient charges for failure to pre-certify admission.]

HOSPITAL BENEFITS	
Inpatient Care	[100%] of the Eligible Charge [[USD 100] deductible
Parental Accommodation—hospital charges for one parent or legal guardian accompanying child under the age of 12	[100%] of the Eligible Charge [USD 500] maximum per inpatient admission
Outpatient Care	[100%] of the Eligible Charge [USD 50] Copayment
Emergency Care	[100%] of the Eligible Charge [No] Copayment
PHYSICIAN BENEFITS	
Surgical Care	[100%] of the Eligible Charge or Maximum Allowance [No] Copayment
Additional Surgical Opinion	[100%] of the Claim Charge [No] Copayment
Medical Care	[100%] of the Eligible Charge or Maximum Allowance [USD 50] Copayment
Emergency Accident or Emergency Medical Care	[100%] of the Eligible Charge or Maximum Allowance [No] Copayment
Other Physician Services—consultations, chemotherapy, therapy treatments, diagnostic service, and spinal manipulation	[100%] of the Eligible Charge or Maximum Allowance [USD 50] Copayment
PREVENTIVE CARE SERVICES	
Diabetes self–management training and education, pap smear test, mammograms, prostate test and digital rectal exam, colorectal cancer screening, wellness care and pediatric preventive care	[100%] of the Eligible Charge or Maximum Allowance [USD 50] Copayment
OTHER COVERED SERVICES	
Blood, braces, dental accident care, allergy shots, oxygen, medical and surgical dressings, durable medical equipment, prosthetic appliances, optometric services, private duty nursing services, ambulance transportation, acupuncture and hearing aids	[100%] of the Eligible Charge or Maximum Allowance
SPECIAL CONDITIONS	
Human Organ Transplant Limit	[USD 150,000] per transplant
Cardiac Rehabilitation Services	[100%] of the Eligible Charge
Ambulatory Surgical Facility	[100%] of the Eligible Charge
Skilled Nursing Facility	[100%] of the Eligible Charge
Substance Abuse Rehabilitation Treatment	
--Inpatient Substance Abuse Rehabilitation Treatment	[100%] of the Eligible Charge
--Outpatient Substance Abuse Rehabilitation Treatment	[100%] of the Eligible Charge

SPECIAL CONDITIONS (continued)	
Mental Illness	
--Inpatient treatment	[100%] of the Eligible Charge
--Outpatient treatment	[100%] of the Eligible Charge
Maternity Service	[100%] of the Eligible Charge
Infertility	[not less than 80%] of the Eligible Charge
Temporomandibular Joint Dysfunction and Related Disorders	[USD 2,5000] annual maximum
Mastectomy Related Services	[100%] of the Eligible Charge
[HOSPICE CARE PROGRAM]	[100% of the Eligible Charge [[USD 100] deductible]
[MEDICAL EVACUATION and REPATRIATION]	
Medical Evacuation or Repatriation	[100%] of the Eligible Charge
Companion Ticket	One economy class round trip airfare
Additional Travel Expenses after Medical Evacuation	Reasonable and necessary airfare
Repatriation of Mortal Remains	Reasonable and necessary expenses
Transportation of Minor Children	Cost of economy class one way fare
[OUTPATIENT PRESCRIPTION DRUG PROGRAM]	
Annual limit	[USD 500]
Copayment	[USD 25.00] per prescription
[DENTAL BENEFITS]	
Benefit Period Maximum	[USD 1,500]
Deductible	[USD 100] per Benefit Period
Preventive Services Benefit Payment Level	[100%] of the Eligible Charge
Primary Services Benefit Payment Level	[100%] of the Eligible Charge
Major Services Benefit Payment Level	[100%] of the Eligible Charge
Orthodontic Services Period Maximum	[USD 3,000]
Orthodontic Services Benefit Payment Level	[100%] of the Eligible Charge
A dental inspection with all necessary dental treatment must have taken place in the 12-month period immediately prior to your Coverage Date or immediately prior to claiming dental benefits.	
[VISION CARE BENEFITS]	
Vision Examination	[$55] per exam, limited to one exam every [24] months
[Single vision lenses]	[$75 per pair]
[Bifocal single lenses]	[$80 per pair]
[Bifocal double lenses]	[$85 per pair]
[Trifocal lenses]	[$90 per pair]
[Lenticular lenses]	[$115 per pair]
[Contact lenses]	[$150 per pair]
[Frames]	[[$100] per Frame, limited to one Frame every {24} months]

PREMIUM

Premium: [USD X,XXX.XX]

[If the premium shown above is over [USD 200,000], the group may elect to pay on a quarterly or semi annual basis.]

Premium Payable: [__Annually] [__Semi-Annual] [__Quarterly]

The undersigned Group hereby agrees to be a participant in the BlueWorldwide Expat℠ Group Insurance Trust, entered into in the state of Delaware by and between Fort Dearborn Life Insurance Company ("FDL") and The [Trustee Bank] (Trustee). The Trustee is the policyholder of certain policies issued by FDL.

The Group agrees to be bound by the terms of the Trust, including any amendments thereto, as long as the Group remains a participant.

The Group further requests that the insurance coverage indicated above be provided for its eligible employees under the BlueWorldwide Expat℠ program policy or policies issued by FDL to the Trustee and subject to the applicable underwriting requirements of FDL, that such insurance coverage become effective as of the requested effective date stated below.

The Group further agrees to accept returning employees and their eligible dependents covered under the BlueWorldwide Expat℠ program into the Group's existing domestic health insurance benefit program upon the return of employees and their eligible dependents to the United States.

The insurance benefits provided shall be in accordance with the terms of the BlueWorldwide Expat℠ Program Policy or policies issued to the Trustee. It is understood and agreed that no coverage shall become effective as to any person who is a U.S. resident or not a full-time employee and further, that, no one other than an executive officer of FDL can change or waive any of FDL's requirements or rights.

Compliance with Foreign Laws: The Group understands that as an employer doing business and employing persons in foreign jurisdiction(s), the Group may be subject to foreign laws with respect to the provision of employee benefits and the insurance of those benefits. The Group understands and agrees that neither the [Trustee Bank] nor FDL have conducted an investigation into whether or how the participation of the Group in the BlueWorldwide Expat℠ program and the insurance of the Group's overseas employees through the BlueWorldwide Expat℠ program complies with the laws of any foreign jurisdiction in which the Group does business or employs persons. The Group further understands and agrees that the Group is solely responsible for compliance (and for any failure to comply) with those foreign laws. The Group also understands that the insurance policy delivered to the Trust is subject to the laws of Delaware.

On behalf of the Group and its Covered Persons, the Group hereby expressly acknowledges its understanding that the Policy constitutes a contract solely between the Group and FDL. FDL is an independent corporation operating under a license with the Blue Cross and Blue Shield Association (the "Association"), an association of independent Blue Cross and Blue Shield Plans. The Association permits FDL to use the Blue Cross and Blue Shield Service Mark and FDL is not contracting as the agent of the Association.

If this Application is accepted by FDL, the Group understands and agrees that such acceptance is granted solely in reliance by FDL on the completeness and accuracy of this Application, the BlueWorldwide Expat℠ Group Quotation Form and any other underwriting data submitted by or on behalf of the Group.

The Group represents to the best of its knowledge and belief, that such information submitted by or on its behalf is complete and accurate.

{Original application for coverage effective [01/01/08].}

{Applicable for coverage revision effective [ ].}

IN WITNESS WHEREOF and intending to be legally bound, the Group has signed this Application on [01/01/08].

[XYZ COMPANY]_____
(Group)

Accepted on _____[01/01/08]_____

By:_____
Title: [VICE PRESIDENT]

[ABC ADMINISTRATOR COMPANY]
(Authorized Administrator for Fort Dearborn Life Insurance Company)

Accepted on _____[01/01/08]_____

By:_____
Title: [PRESIDENT]

SERFF Tracking Number:	*FDLA-125601712*	*State:*	*Arkansas*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*38683*
Company Tracking Number:	*AH-4/9-4100108 DEAR*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al.*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FDLA-125601712*	*State:*	*Arkansas*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*38683*
Company Tracking Number:	*AH-4/9-4100108 DEAR*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al.*		

Supporting Document Schedules

Review Status:

Bypassed -Name: Certification/Notice — Approved-Closed — 04/21/2008

Bypass Reason: We have not submitted any certification(s) with this submission, which is filed for INFORMATION ONLY. Because no Arkansas residents will be covered under this out-of-state major medical policy, it is our opinion that this coverage is not subject to the Arkansas Insurance Code.

Comments:

Review Status:

Bypassed -Name: Application — Approved-Closed — 04/21/2008

Bypass Reason: The application is being submitted under the Form Schedule tab.

Comments:

Review Status:

Satisfied -Name: Group Insurance Trust Agreement — Approved-Closed — 04/21/2008

Comments:

Attachment:

Group Insurance Trust Agreement.pdf

Review Status:

Satisfied -Name: Delaware - Trust Situs State Approval — Approved-Closed — 04/21/2008

Comments:

Attachment:

DE Approval FDLA-125458850.pdf

Review Status:

Satisfied -Name: Actuarial Memorandum — Approved-Closed — 04/21/2008

Comments:

Attachment:

ACT MEMO signed.pdf

GROUP INSURANCE TRUST AGREEMENT

This Trust Agreement (the "Agreement") is made and entered into by and between Fort Dearborn Life Insurance Company, an Illinois domiciled life insurance company, (the "Settlor"), and Wilmington Trust Company, a Delaware Banking Corporation ("Trustee"), as follows:

WHEREAS, the Settlor desires to issue a group master insurance policy ("Group Policy") to be held by the Trustee for the benefit of those employer groups eligible to participate in the Blue Worldwide Expat Program, including those groups described in the Eligible Groups Addendum of this Agreement, (such addendum being attached hereto and made a part hereof) and

WHEREAS, Settlor hereby desires to create and maintain this Trust to facilitate same, and

WHEREAS, the Trustee has consented to serve as Trustee of this Trust,

NOW, THEREFORE, the parties agree as follows:

Section 1. Name, Situs and Construction of the Trust

The Trust hereby created shall be known as the Blue Worldwide Expat Group Insurance Trust. The Trust established hereby is created and accepted in the State of Delaware and shall be governed by and construed in accordance with the laws of the State of Delaware. If any portion of this Agreement shall be held by a court of competent jurisdiction to be illegal or unenforceable, such determinations shall affect only such provision and all other provisions of this Agreement shall be construed and interpreted in such a manner as to give effect to the intention of the parties hereto, as evidenced by the terms of this Agreement taken as a whole. Whenever the context shall so require, all singular words herein shall include the plural and all plural words shall include the singular.

Section 2. Definition of Terms

"Administrator" means a person or an organization appointed by the Settlor to act on its behalf to issue Certificates to Covered Persons under the Group Policy and to perform other duties as set forth in this Agreement.

"Certificate" means any certificate of health care benefits issued to a Covered Person by the Administrator under the Group Policy.

"Covered Person(s)" means any person entitled to receive benefits under the Policy.

"Group Policy" or "Policy" means the group master policy, together with any riders, endorsements or amendments, issued by the Settlor to the Trust and which funds the

Trust. The Policy provides health coverage to employees of employer groups participating in the Blue Worldwide Expat Program when such employees, their spouses and/or dependents reside outside of the United States for an extended period of time

"Settlor" means Fort Dearborn Life Insurance Company or FDL.

"Trust" means, unless the context indicates otherwise, the BlueWorldwide Expat Group Insurance Trust hereby established.

"Trust Fund" means the Policy held by the Trustee pursuant to this Agreement.

"Trustee" means the Trustee herein designated or any successor designated as provided
herein.

Section 3. Administration

The Trust hereby established shall be administered in accordance with and governed by the relevant rules, regulations and statutes of the State of Delaware now in effect and as hereafter amended and enacted. Neither the Trustee nor any Administrator shall incur any liability as a result of adherence to applicable rules, regulations and statutes, notwithstanding that same may be contrary to or inconsistent with the terms hereof.

The Administrator shall be responsible for issuing Certificates under the Policy and for the administration of all matters with respect to the Trust which are not expressly reserved to the Trustee by the specific provisions of this Agreement. In addition, the Administrator shall have the specific rights and responsibilities set forth in Section 7 hereof. In no event shall the administration of the Trust be deemed to include responsibility for administration of the Policy as explained in greater detail in Section 7 hereof.

Section 4. Trustee

The sole responsibility of the Trustee hereunder shall be to serve as the policyholder for the Policy issued under this Trust. The Trustee is empowered to take such actions as are required
or reasonably necessary to fulfill that responsibility as set forth in this Section, subject to the
following:

(a) The Trustee shall not be responsible for determining the appropriateness of the Policy, collecting, accounting for or forwarding any premium payments, administering the operations of the Trust, determining or paying any benefits payable under the Policy, or exercising any rights or performing any responsibilities delegated to the Administrator or the Settlor by the provisions

of this Agreement, even though the Settlor or Administrator may fail or refuse to discharge those responsibilities delegated to it hereunder. The Trustee assumes and shall have no responsibility or liability for the administration of benefits provided by the Policy. The Trustee shall not be deemed to be a guarantor of the solvency of the Settlor or be liable for the failure, refusal or inability of the Settlor or its Administrator to make any payment or payments required by the Policy.

(b) The Trustee shall execute any and all documents approved by the Settlor which are reasonably required in connection with the acquisition, maintenance, modification or termination of the Policy, provided that such documents do not increase the liability or responsibilities of the Trustee hereunder.

(c) Any written notices of any kind received by the Trustee in connection with its service as Trustee under this Agreement shall be immediately forwarded by the Trustee to the Settlor.

(d) The Trustee need not exercise any right or perform any responsibility that the Trustee may have as holder of the Policy without the prior written approval of the Settlor. Notwithstanding any provision contained herein to the contrary, the Settlor shall defend, indemnify and hold the Trustee, including its officers, directors, and employees harmless from any and all claims and liabilities, including attorney fees, which may be incurred by it as a result of its acceptance of or action or inaction pursuant to the terms of the Trust Agreement. Such indemnification shall survive the Trustee's resignation or removal, or the termination of this Agreement until extinguished by an applicable statute of limitations. The Trustee shall have the right to require, and upon request the Settlor shall provide, any and all information in the possession or control of the Settlor that the Trustee may reasonably require in connection with the exercise of its rights or the performance of its responsibilities hereunder.

(e) The Trustee shall not be required to expend any of its own funds relative to printing, mailing, or other such costs in connection with the administration of the Trust or any marketing activity thereunder.

(f) The Trustee shall not be liable for the collection or payment of any premiums under the Policy.

(g) In the event that any assets of the Trust shall be attached, garnished or levied upon by any court order, or the delivery thereof shall be stayed or enjoined by an order of a court, or any order, judgment or decree shall be made or entered by any court, affecting the assets of the Trust, the Trustee is expressly authorized, in its sole discretion, to obey and comply with all writs, orders or decrees so entered or issued, when it is advised by legal counsel of

its own choosing that it is binding upon it, whether with or without jurisdiction, and in the event that the Trustee obeys or complies with any such writ, order or decree, it shall not be liable to any of the parties hereto or to any other person, firm or corporation, by reason of such compliance notwithstanding such writ, order or decree be subsequently reversed, modified, annulled, set aside or vacated.

Section 5. Compensation of Trustee

For its service as Trustee hereunder, the Settlor shall pay the Trustee reasonable compensation per Exhibit A, such exhibit being attached hereto and made a part hereof

Section 6. Resignation or Removal of the Trustee

The Trustee may resign at any time upon 60 days prior written notice to the Settlor, unless the Settlor shall accept as adequate a shorter period of notice. Upon the resignation of the Trustee under circumstances in which the Trust will continue, the Settlor shall appoint a successor Trustee. The Settlor may remove the Trustee at any time, with or without cause, upon written notice to the Trustee stating the effective date of such removal, which date shall not be earlier than the date of delivery of such notice. Upon the removal of the Trustee under circumstances in which the Trust will continue, such notice of removal shall designate a successor Trustee. If the Settlor fails to appoint a successor Trustee prior to the effective date of the Trustee's resignation or removal, the Trustee shall have no further right or responsibility hereunder except that the Trustee shall request that the Settlor designate a successor Trustee and Trustee shall immediately transfer the Policy to a successor Trustee. If the Settlor declines or fails to designate a successor Trustee within five days of the Trustee's request, the Trustee shall surrender the Policy to a successor Trustee designated by the Director of Insurance of the State of Delaware. Any individual, or any corporation or association legally empowered to exercise Trust powers, having a business officer in the State of Delaware, shall be eligible to be appointed a successor Trustee. Upon the resignation or removal of a Trustee, unless the Trust then terminates, such Trustee shall assign, transfer, convey and deliver to the successor Trustee all of its interest in the Policy and such other Trust property as is then in its possession or control, and shall thereupon be fully released and discharged from any further obligations and liabilities hereunder, and the successor Trustee shall succeed to and be vested with all the rights and responsibilities of the Trustee hereunder. Any party who becomes a successor to a Trustee through sale or transfer of its business, consolidation, merger, or other corporate reorganization, shall automatically become a successor Trustee and shall succeed to all right, title, and interest of the prior Trustee and shall succeed to and be vested with all of the rights and responsibilities of the Trustee hereunder.

Section 7. Rights and Responsibilities of the Settlor

The Settlor, through its Administrator, will administer the group insurance program of which this Trust is a part. The Settlor, through its Administrator, shall perform all

administrative and other responsibilities with respect to the group insurance program of which this Trust is a part and which are not expressly designated as responsibilities of the Trustee under Section 4. Those responsibilities shall include, but shall not be limited to, the following:

(a) The Settlor shall bear all expenses incurred by the Trustee in connection with the establishment, administration, amendment and termination of the Trust.

(b) The Settlor shall be responsible for construing the provisions of this Agreement, and in doing so may take any and all actions necessary to correct any defect, supply any omission or reconcile any inconsistency in such a manner and to such extent as it shall deem necessary or advisable to carry out the purposes hereof.

(c) The Settlor shall perform such other responsibilities and shall exercise such other rights as shall be reasonably necessary to effectuate the purpose of the Trust.

The authority and responsibility of the Administrator shall be determined by agreement between the Settlor and the Administrator. Settlor may, at any time, appoint another organization to serve as Administrator hereunder upon written notice to the Trustee. The Trustee shall not be responsible in any way for the selection or continued retention of the Administrator, such selection and retention being entirely the responsibility of the Settlor.

Section 8. Amendments

This Agreement may be amended at any time by a written amendment executed by the Trustee and Settlor. No notice of an amendment hereto need be given any Covered Person unless such amendment may have a material adverse impact on a Covered Person, in which event written notice of the fact and substance of such amendment shall be given by the Administrator to each such Covered Person so impacted.

Section 9. Termination of Trust

The Settlor may terminate this Trust in its entirety by written notice to the Trustee. Such notice shall state that the Settlor has elected to declare the Trust terminated effective as of a specific date, which date shall be the end of the calendar month not less than 30 days after the date of the mailing of such notice.

Section 10. Third Parties

Any right to an insurance benefit provided by the Policy shall exist only to the extent such benefit is provided by the terms and conditions of the Policy and this Trust. The Settlor, Administrator, and Trustee shall have no liability to any third party by reason of the establishment, administration, amendment and termination of the Trust.

Section 11. Notices

Any notice required or permitted to be given by this Agreement or by any applicable law or regulation shall be effective if delivered in person or sent by United States mail, postage prepaid and addressed to the parties as shown below. However, any notice required or permitted to be given to both the Settlor and Administrator may be given in a single notice at the address and attention of the Settlor.

To the Trustee:

Wilmington Trust Company
Attn: David B. Young
1100 North Market Street
Rodney Square North
Wilmington, DE 19890-1625
Telephone: 302-636-5216
Fax: 302-636-4149

To the Settlor:

Fort Dearborn Life Insurance Company
Attn: Victoria E. Fimea, Vice President,
General Counsel & Secretary
1020 31st Street
Downers Grove, IL 60515-5591
Telephone: 630-824-5684
Fax: 630-824-6255

This Agreement may be executed in as many counterparts (duplicates and reproductions of the original) as may be necessary and required to accomplish the purposes of this Agreement, each of which shall be deemed to be an original, but all of which together at any given time shall constitute one and the same instrument for all purposes.

SETTLOR:

ATTEST:

By: _____ By: _____
VICTORIA E. FIMEA

Title: VICE PRESIDENT, GENERAL COUNSEL & SECRETARY - 2/18/08 Title: ASSISTANT SECRETARY 2/18/08

TRUSTEE:

WILMINGTON TRUST COMPANY not in its
Individual capacity but as Trustee ATTEST:

By: _____ By: _____

Title: Margaret Pulgini Vice President Title: David B. Young Assistant Vice President

ELIGIBLE GROUPS ADDENDUM

This Eligible Groups Addendum (the "Addendum") is made part of the Trust Agreement.

An Eligible Group is a United States based employer which has certain employees and their spouses and/or dependents residing outside of the United States for an extended period of time and which employees desire to be covered under the terms of the Policy issued to this Trust. Coverage under the Policy will be evidenced by a Certificate issued by the Administrator to the employee as a Covered Person under the Policy.

EXHIBIT A

TRUSTEES FEES:

Upon the establishment of the Trust, the Settlor shall pay Trustee a one-time charge of $2,000.00 as an initial setup fee PLUS an annual service fee of $2,500.00, with a $2,500.00 annual service fee due on the anniversary of the Agreement every year thereafter until terminated.

SERFF Tracking Number:	*FDLA-125458850*	*State:*	*Delaware*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*21643*
Company Tracking Number:	*SM-12908-4100108DE-DE*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al*		

Filing at a Glance

Company: Fort Dearborn Life Insurance Company

Product Name: Group Health Insurance - Major Medical	SERFF Tr Num: FDLA-125458850	State: DelawareLRF
TOI: H16G Group Health - Major Medical	SERFF Status: Closed	State Tr Num: 21643
Sub-TOI: H16G.001C Any Size Group - Other	Co Tr Num: SM-12908-4100108DE-DE	State Status: Filed
Filing Type: Form	Co Status:	Reviewer(s): Jennifer Dawson (LRF), Linda Nemes (LRF)
	Author: Sharon Mathews	Disposition Date: 03/26/2008
	Date Submitted: 02/28/2008	Disposition Status: Filed
Implementation Date Requested: On Approval		Implementation Date:

General Information

Project Name: Expat	Status of Filing in Domicile: Not Filed
Project Number: 4-100-108 DE, et al	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Trust
Filing Status Changed: 03/26/2008	Company Status Changed:
State Status Changed: 03/26/2008	Deemer Date:
Created By: Sharon Mathews	Submitted By: Sharon Mathews

Corresponding Filing Tracking Number:

Filing Description:

Re: Fort Dearborn Life Insurance Company; NAIC No. 71129

Discretionary Group Approval – Expatriate Group; and

New Group Health Form/Rate Filing: Expatriate Program

Form Numbers Description:

4-100-108 DE Group Master Policy

9-100-108 DE Benefit Program Application

SERFF Tracking Number:	*FDLA-125458850*	*State:*	*Delaware*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*21643*
Company Tracking Number:	*SM-12908-4100108DE-DE*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al*		

4-200-108 Certificate of Health Care Benefits

4-200A-108 Schedule of Benefits

Dear Reviewer:

Fort Dearborn Life Insurance Company (FDL) has agreed to replace the underwriting company for the existing Expatriate Program described below upon your approval of the discretionary group and this new group health form/rate filing. These forms/rates do not replace any previously filed with your Department.

The policy will be issued to Wilmington Trust Company (Trustee) situsedin Delaware to provide health coverage under the policy for US citizens who have been assigned by their employer to a position that requires them to reside outside the United States as a condition of their employment. This health coverage will be sold only to group clients of Blue Cross and/or Blue Shield Plans that participate in the BlueWorldwide Expat℠ Program. There will be no coverage provided to individuals residing in Delaware or anywhere in the United States.

In support of the discretionary group for which we request your approval, we have included, as part of the Actuarial Memorandum, Actuarial Certification of compliance with Delaware Title 18 § 3509 as follows:

1. The issuance of such group policy is not contrary to the best interest of the public;
2. The issuance of the group policy would result in economies of acquisition or administration;
3. The benefits are reasonable in relation to the premiums charged; and
4. The group is not affiliated with or controlled by (as those terms are defined in Chapter 50 of this title) an insurer unless approved by the Commissioner.

The filed forms contain bracketed items indicating variability.

An Actuarial Memorandum and Rates are included. Additional filing requirements are being submitted, where applicable.

If you have any questions or need additional information, please contact me at 1-800-633-3696, 630 824-6009 or sharon_mathews@fdlic.com.

SERFF Tracking Number:	*FDLA-125458850*	*State:*	*Delaware*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*21643*
Company Tracking Number:	*SM-12908-4100108DE-DE*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al*		

Thank you for your prompt response.

Sincerely,

Sharon A. Mathews, AIRC, HIA
Advanced Contract Specialist

Company and Contact

Filing Contact Information

Sharon Mathews, Senior Compliance Specialist sharon_mathews@fdlic.com
1020 31ST STREET (630) 824-6009 [Phone]
DOWNERS GROVE, IL 60515 (630) 824-5428[FAX]

Filing Company Information

Fort Dearborn Life Insurance Company	CoCode: 71129	State of Domicile: Illinois
1020 31st Street	Group Code: 917	Company Type: Life and Health
Downers Grove, IL 60515-5591	Group Name:	State ID Number:
(800) 633-3696 ext. [Phone]	FEIN Number: 36-2598882	

Filing Fees

Fee Required?	Yes
Fee Amount:	$200.00
Retaliatory?	No
Fee Explanation:	$50.00 per form X 4 forms = $200.00
Per Company:	Yes

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Fort Dearborn Life Insurance Company	$200.00	02/28/2008	18220025

SERFF Tracking Number:	*FDLA-125458850*	*State:*	*Delaware*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*21643*
Company Tracking Number:	*SM-12908-4100108DE-DE*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Jennifer Dawson (LRF)	03/26/2008	03/26/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Group Insurance Trust Agreement	Supporting Document	Sharon Mathews	03/12/2008	03/12/2008
Benefit Program Application	Form	Sharon Mathews	03/07/2008	03/07/2008
LH - Filing Fee Form	Supporting Document	Sharon Mathews	03/03/2008	03/03/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Fee Form	Note To Filer	Jennifer Dawson (LRF)	03/03/2008	03/03/2008

SERFF Tracking Number:	*FDLA-125458850*	*State:*	*Delaware*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*21643*
Company Tracking Number:	*SM-12908-4100108DE-DE*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al*		

Disposition

Disposition Date: 03/26/2008
Implementation Date:
Status: Filed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FDLA-125458850*	*State:*	*Delaware*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*21643*
Company Tracking Number:	*SM-12908-4100108DE-DE*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al*		

Item Type	Item Name	Item Status	Public Access
Supporting Document *(revised)*	LH - Filing Fee Form		Yes
Supporting Document	LH - Filing Fee Form		No
Supporting Document	LH - State Specific Requirements		Yes
Supporting Document	Actuarial Memorandum		No
Supporting Document	Group Insurance Trust Agreement		No
Form	Group master Policy		Yes
Form	Certificate of Health Care Benefits		Yes
Form	Schedule of Benefits		Yes
Form *(revised)*	Benefit Program Application		Yes
Form	Benefit Program Application		No

SERFF Tracking Number:	*FDLA-125458850*	*State:*	*Delaware*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*21643*
Company Tracking Number:	*SM-12908-4100108DE-DE*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al*		

Amendment Letter

Amendment Date:

Submitted Date: 03/12/2008

Comments:

Dear Reviewer,

For informational purposes, we are attaching a copy of the group insurance trust agreement entered into by and between Fort Dearborn Life Insurance Company and Wilmington Trust Company, a Delaware Banking Corporation. The group master policy will be issued to Wilmington Trust Company to provide health coverage under the policy for US citizens who have been assigned by their employer to a position that requires them to reside outside the United States as a condition of their employment.

Sincerely,

Sharon A. Mathews, AIRC, HIA
Advanced Contract Specialist

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Group Insurance Trust Agreement

Comment:

Group Insurance Trust Agreement.pdf

SERFF Tracking Number:	*FDLA-125458850*	*State:*	*Delaware*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*21643*
Company Tracking Number:	*SM-12908-4100108DE-DE*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al*		

Amendment Letter

Amendment Date:

Submitted Date: 03/07/2008

Comments:

Dear Reviewer,

In reviewing the forms submitted to you on 2/28/08, I found that I attached the wrong copy of form 9-100-108 DE, the Benefit Program Application. The correct copy is now attached. A caption for "Dependent Coverage" under Eligibility on page 2 was changed to "Family Coverage." Also, a sentence describing the Limiting Age for dependent children has been added.

Sincerely,

Sharon A. Mathews, AIRC, HIA
Advanced Contract Specialist

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
9-100-108 DE	Application/Enrollment Form	Benefit Program Application	Initial				42	BPA 9-100-108 DE revised 3-7-08.doc

SERFF Tracking Number:	*FDLA-125458850*	*State:*	*Delaware*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*21643*
Company Tracking Number:	*SM-12908-4100108DE-DE*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al*		

Amendment Letter

Amendment Date:

Submitted Date: 03/03/2008

Comments:

The Filing Fee Form is attached.

Changed Items:

Supporting Document Schedule Item Changes:

Satisfied -Name: LH - Filing Fee Form

Comment:

LH - Filing Fee Form Expat.pdf

SERFF Tracking Number:	*FDLA-125458850*	*State:*	*Delaware*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*21643*
Company Tracking Number:	*SM-12908-4100108DE-DE*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al*		

Note To Filer

Created By:

Jennifer Dawson (LRF) on 03/03/2008 07:54 AM

Subject:

Filing Fee Form

Comments:

Please complete the attached form and submit via SERFF.

State of Delaware
Life & Health Filing Fee Form

Department Use Only

Tracking #: _____

Company Name on Check _____

Group Name _____

Check/EFT Amount _____

Total # of Forms (Please itemize forms below) _____

Check # or EFT Transaction # _____

Company Filing Number _____

Date of Check or EFT Transaction _____

SERFF Tracking Number (If Applicable) _____

Date Check Mailed _____

Typ e of Filing Life ☐ Health ☐

Effective Date of Filing _____

Check Appropriate Block(s) Rates ☐ Advertisements ☐ Forms ☐

Check Appropriate Block(s) Credit Life ☐ Credit A&H ☐ Group Life ☐ Group A&H ☐ Group Annuity ☐
Individual A&H ☐ Other Life ☐ Other A&H ☐ Other Annuity ☐

Filing Fees are: $50 per Form, per Rate, per Company, per Filing. Advertisements are $50 per Filing per Company.

NAIC #	Company Name	Form Number	Description	Fee Total

Grand Total

Print Form

Reset Form

Mail to:
Delaware Insurance Department
Rates and Forms
841 Silver Lake Blvd.
Dover, DE 19904

You may attach additional filing fee forms as needed

SERFF Tracking Number:	*FDLA-125458850*	*State:*	*Delaware*
Filing Company:	*Fort Dearborn Life Insurance Company*	*State Tracking Number:*	*21643*
Company Tracking Number:	*SM-12908-4100108DE-DE*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Group Health Insurance - Major Medical*		
Project Name/Number:	*Expat/4-100-108 DE, et al*		

Form Schedule

Lead Form Number: 4-100-108 DE

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	4-100-108 DE	Policy/Contract/Fraternal Certificate	Group master Policy	Initial		40	POLICY 4-100-108 DE.pdf
	4-200-108	Certificate	Certificate of Health Care Benefits	Initial		52	CERT 4-200-108.pdf
	4-200A-108	Schedule Pages	Schedule of Benefits	Initial		51	CERT SOB 4-200A-108.pdf
	9-100-108 DE	Application/ Enrollment Form	Benefit Program Application	Initial		42	BPA 9-100-108 DE revised 3-7-08.doc

FORT DEARBORN LIFE INSURANCE COMPANY
ACTUARIAL MEMORANDUM

POLICY FORMS: 4-100-108 DE

PURPOSE OF FILING:
The purpose of this rate filing is to demonstrate the reasonableness of rates in relation to the benefits. The filing may not be appropriate for other purposes.

GENERAL DESCRIPTION OF BENEFITS:
These plans are being offered by Fort Dearborn Life for the first time and the benefits are reflected in the Blue Worldwide Expat℠ Schedule of Benefits as filed. There are two benefits, the Standard Option and the High Option. Both are included within the parameters of the filed Schedule of Benefits.

RATES:
Rates are given in the table below and will be effective throughout the remainder of 2008

Age	Standard Option	High Option
0 -18	1,898	2,232
19 - 24	3,387	3,984
25 - 29	3,691	4,342
30 - 34	3,917	4,609
35 - 39	4,230	4,976
40 - 44	5,063	5,956
45 - 49	7,454	8,770
50 - 54	7,883	9,273
55 - 59	10,476	12,325
60 - 64	11,403	13,416
65 - 69	23,327	27,445

RATE GUARANTEES:
Rates are guaranteed for one year. They may then be adjusted for experience prospectively.

ANTICIPATED RATE INCREASES:
It is anticipated that rates will rise 3% per year.

ANTICIPATED LOSS RATIO:
The target loss ratio for these plans is 55%.

ACTUARIAL CERTIFICATION:

We certify that the discretionary group for which we request your approval complies with Delaware Title 18 § 3509 as follows:

1. The issuance of such group policy is not contrary to the best interest of the public;
2. The issuance of the group policy would result in economies of acquisition or administration;
3. The benefits are reasonable in relation to the premiums charged; and
4. The group is not affiliated with or controlled by (as those terms are defined in Chapter 50 of this title) an insurer unless approved by the Commissioner.

James A. Wiseman

James A. Wiseman F.S.A., M.A.A.A. Date: February 25, 2008